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MANAGING PROFESSIONAL ROLES IN HOME-BASED FAMILY THERAPY:
A STUDY OF MARRIAGE AND FAMILY THERAPIST PRACTICES

A Dissertation Presented to
The Faculty of the Applied Psychology Department
Antioch University New England

In Partial Fulfillment of the Requirements of the Degree
Doctor of Philosophy in Marriage and Family Therapy

Sharon Fitzgerald, M.A., LMFT

October 2019

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Antioch University New England

Keene, New Hampshire

Applied Psychology Department

October 15, 2019

We Hereby Recommend that the Dissertation By

Sharon Fitzgerald

Entitled

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Doctor of Philosophy in Marriage and Family Therapy

APPROVED BY:

DISSERTATION CHAIR

Kevin Lyness, PhD

COMMITTEE MEMBER

Megan Murphy, PhD

COMMITTEE MEMBER

Barbara Andrews, PhD

DEPARTMENT OF APPLIED PSYCHOLOGY REPRESENTATIVE

Kevin Lyness, PhD

Dedication

This dissertation is dedicated to Ada, Irene, Garnet, Jasper, and Emrys.

Thank you for waiting.

Acknowledgements

I have respect and gratitude for the 12 therapists who stepped away from their busy schedules to share their experience and knowledge of home-based family therapy with me. Likewise, I thank the many families that have invited me into their homes over the years, providing me with opportunities to reflect on our work together. I am grateful to the students and supervisees whose questions, challenges, and curiosity provided food for thought.

I thank my dissertation chair, Kevin Lyness, PhD for being accessible when sought out, and for encouraging independent thinking with tacit support. I thank Megan Murphy, PhD whose skill in dialogic conversation helped me articulate the research question. I also extend gratitude to Barbara Andrews, PhD for taking the time to be part of this project. Thank you all.

I am grateful for the early morning laughter that I have shared with Abby Jones in the library: each chuckle is worth a thousand words. I deeply appreciate the attention to detail offered by Pippin Macdonald. The library was a haven where progress was applauded and questions answered.

Finally, I extend a prayer of gratitude for the roles played by Joanne Grassia and Mirza Lugardo as colleagues, fellow travelers, and most of all, wise women at my side listening to ideas in their raw form, to Jak Berg for her enthusiastic support, and to Steve and Vic, who offered alternative frames for viewing the situation, encouraging me to see my way to the end despite the many intervening life events. The value of social support is immeasurable.

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Abstract

Since the 1980's there has been a proliferation of home and community-based mental health services developed to meet the needs of families with children with severe emotional or behavioral problems as an alternative to residential or institutional placement (Macchi & O'Connor, 2010; Zarski, Pastore, Way, & Shepler, 1988). Despite this long history, home-based family therapists are still trying to define best practices for home-based family therapy (HBFT). In the literature, the management of professional roles has been defined as a practice element worthy of attention. For instance, in an analysis of home-based programs, researchers identified providers having multiple roles as one of nine program elements that were effective in preventing placement of youth with behavioral and mental health needs (Lee et al., 2014). However, studies of clinicians providing HBFT indicate that multiple roles and associated boundary issues often present ethical challenges (Snyder & McCollum, 1999; Stinchfield, 2004; Worth & Blow, 2010). A constructivist grounded theory methodology was followed to address the question: How do marriage and family therapists manage multiple professional roles in the context of providing home-based family therapy? Twelve MFTs with experience in HBFT participated in semi-structured interviews, contributing their experience and knowledge to the construction of a pragmatic model of being professional and cultivating professional agency. Six agentic practices were identified, labeled as reflective, communicative, adaptive, proactive, relational, and sustaining practices. This model contributes to understanding professionalism in home-based family therapy and adds to the broader discussion of managing multiple roles other multi-disciplinary settings.

Keywords: home-based family therapy, professional agency, professionalism, reflective practice, professional role

CHAPTER 1

Contextual Background

Since the 1980's there has been a proliferation of home and community-based mental health services developed to meet the needs of families with children with severe emotional or behavioral problems as an alternative to residential or institutional placement (Macchi & O'Connor, 2010; Zarski, et al., 1988). Typically, these home-based programs are short-term, time-delimited interventions provided by a team of therapists and paraprofessionals who have a small caseload. According to the home-based framework, therapists work on a flexible schedule on the basis of family and therapist need, and services are available on a 24/7 basis (Quinones, 2013; Stinchfield, 2004; Zarski et al., 1988). Generically these services have been referred to as *home-based family therapy*, *in-home family therapy*, or *family-based therapy*. In this paper, I will use home-based family therapy (HBFT) to refer to intensive mental health service models that are offered to families in the home.

HBFT has a long history of being used with families with children or youth at risk of placement. Several models of HBFT have established empirical credibility, and family-based interventions are supported by federal and state funding initiatives (U.S. Department of Health and Human Services [DHHS], 2010). Under the current policy incentives, the trend towards home-based interventions is likely to increase.

Despite this long history, home-based family therapists are still trying to define best practices for HBFT and there have been renewed calls for recognizing HBFT as a specialization in need of professionalization (Hammond & Czyszczon, 2014). There is a growing body of research identifying the specific competencies that are unique to home-based therapy and the need for specific training (Adams & Maynard, 2000; Macchi & O'Connor, 2010; Stinchfield,

2004; Tate, Lopez, Fox, Love, & McKinney, 2014). Although HBFT models are built on different theoretical frameworks, they share five interconnected components in common: (a) consideration of environment and context, (b) the family's roles and expectations, (c) the therapist's roles and expectations, (d) the therapeutic relationship, and (e) the focus of clinical work (Macchi & O'Connor, 2010). According to analysis of the HBFT literature by Macchi and O'Connor (2010), these specialized skills include "managing proper professional boundaries that honor the distinctions among family member and clinician roles and responsibilities" (pp. 455-456).

The management of professional roles in HBFT has elsewhere been identified as a practice element worthy of attention. For instance, in an analysis of home-based programs, researchers identified providers having multiple roles as one of nine program elements that were effective in preventing placement of youth with behavioral and mental health needs (Lee et al., 2014). However, studies of clinicians providing HBFT indicate that playing multiple roles can be problematic. Researchers have provided evidence of a cluster of role challenges that home-based family therapists are likely to encounter that have raised ethical concerns, including boundary crossings, role ambiguity and role conflict (Roberts, 2006; Wasik & Bryant, 2001; Worth & Blow, 2010). Difficulty with role definition and boundary setting have been identified as common supervisory issues arising in training settings (Jager et al., 2009; Snyder & McCollum, 1999; Thomas, McCollum & Snyder, 1999), as well as in the field (Culbreth, Woodford, Levitt, & May, 2004; Lawson, 2005).

Multiple roles (also referred to as multiple or dual relationships) have been the center of polarizing debates in the mental health professions for decades (Kitchner, 1988; Zur & Lazarus, 2002). At the heart of the debate has been the question whether all non-sexual multiple

relationships should be avoided to prevent risk of exploitation or harm. Besides HBFT there are a few other therapeutic settings, including medical, military and forensic counseling, where therapists have multiple professional roles and increased opportunity for issues concerning boundaries and confidentiality. However, the literature on this topic is primarily descriptive or theoretical. How therapists manage these role challenges in HBFT remains an area to be empirically explored.

Purpose of this Study

The purpose of this qualitative research study was to develop a grounded theory of how marriage and family therapists (MFTs) manage multiple professional roles in home-based family therapy (HBFT) practice settings. The area under investigation was the professional practices of marriage and family therapists who work or have worked in an agency setting, as providers of an intensive home-based service delivery model. The research question that guided this study was: How do marriage and family therapists manage multiple professional roles in HBFT? Data was obtained through in-depth interviews with marriage and family therapists with experience as HBFT clinicians at locations convenient to the therapists. A constructivist grounded theory methodology was used to explicate the processes that the participants revealed to develop a pragmatic description.

Researcher Bias

In the interests of transparency, it should be noted that I did not come to this study with a blank slate: I came to this study having worked as a clinician and supervisor for an agency contracted by juvenile justice (and/or child protective services) to provide intensive in-home therapy to adjudicated adolescents. As a lead clinician, I had a job with many “hats”: In addition to the multiple configurations of therapy (individual, couple, family, group), I was responsible

for case management, which included the roles of intake coordinator (sometimes also fulfilled by a paraprofessional), advocate and educator, and overseeing team adherence to the treatment goals. The intake coordinator crafted the treatment plans that set objectives for each member of the team. The team, which included the family, was comprised of one or two clinicians (depending on the severity of the case), and one or two paraprofessionals who worked individually with the youth (or parents); the referring probation officer or child protective service worker and a school representative would also be party to the treatment plan and monthly progress reports. Clinicians were required to write progress evaluations for the court that were taken into consideration with recommendations from the probation officer for ongoing services or discharge. There was an agency expectation that all team members would cultivate strong collegial relationships with the third-party referral sources. After my first day on the job I wrote the following in my journal:

My first day began with a team meeting that included—in addition to the family of three—13 participants representing juvenile probation, child protective services, the referring school, the current school placement (2), community mental health (2), medical faculty, and the five members of our treatment team. It was standing room only for those who arrived late....Everyone spoke about their role with the family and the youth's progress.

I was aware of the imbalance of power in the room, the position of the family within the systems, and misgivings about my role in the hierarchy between the client and third-party payer.

As a clinician, I combed the literature for guidance on best practices in HBFT specific to managing the type of challenges that frequently arose in this work setting with respect to client confidentiality, third-party interests, and balancing case-management and clinical roles. What

stood out for me in the literature was the gap between the common ethical concerns voiced by the therapists and counselors working in the field and the model HBFT program evaluations that did not address these issues at all. Not finding the desired resources, I undertook a heuristic self-study of my own experience to understand the factors contributing to the dissonances I had encountered in HBFT practice. This journey took me through an examination of my values, biases, and presuppositions about therapeutic relationships.

My personal exploration of best practices in HBFT has led me to undertake this dissertation. In order to establish a starting point, I utilized Clarke's (2005) analytic approach to map out the domain of interest: I created a situational map to articulate those areas that seemed to be relevant to understanding the context of home-based family therapists' professional interactions (See Appendix A). For myself, in order to understand the contextual demands underlying the challenges home-based family therapists face, it was necessary to locate HBFT practice with respect to public policy, organizational elements, and professional discourses that contribute to the experience and actions of home-based family therapists. The following literature review touches on these areas to situate the reader in the larger contextual environment of HBFT practice.

CHAPTER 2

Literature Review

Literature Review in Grounded Theory Studies

Glaser and Strauss (1967) explicitly discouraged conducting a literature review prior to beginning research as it was considered to “contaminate” the emergence of categories from the data (p. 45). This was premised on the notion that an objective theory could emerge from the data provided the researcher did not bring pre-conceived ideas to the analysis. The idea that objective knowledge can be discovered by correctly following grounded theory research methods reflects the modernist perspective associated with Glaser and Strauss, but need not be, as Charmaz (2014) notes, the only epistemological approach to grounded theory. In Charmaz’s adaptation of grounded theory to the constructivist view, the researcher’s subjectivity and experience cannot be removed from the research process: “The theory *depends* on the researcher's view; it does not and cannot stand outside of it” (p. 239). In constructivist grounded theory, the researcher maintains a reflexive stance while constructing theory, prioritizing what is found in the data over the literature to ensure groundedness. The literature review, and previous experience, can provide sensitizing concepts that can orient the researcher to analytical starting points (Charmaz, 2014). From this perspective, the intention of this literature review is to provide a contextual map of existing interests and concerns of HBFT that are relevant to the launching of this study. This literature review is not intended to be exhaustive as it is preceding a grounded theory study, but sufficient to expose the blending of my interpretation of the literature, experience and world view.

HBFT Literature

Literature on HBFT is spread across the mental health professions of social work, mental

health counseling, and marriage and family therapy, mirroring the professional and educational diversity in the delivery of home-based services. While marriage and family therapists are particularly suited to practice home-based family therapy on the basis of their education in family systems and the therapeutic models that underlie HBFT, there are only a few studies specifically focused on MFTs in HBFT and most of the research on the practice of HBFT is written through the lenses of social work or mental health counseling. As HBFT is a multidisciplinary field, when parsing the HBFT literature I found that it was important to be attentive to how the respective professional discourses, affiliations, and educational backgrounds of the researchers and participants might inform the focus and concerns in the literature.

Policy initiatives for HBFT. In the past three decades, there has been an expansion of federal funding of state initiatives to divert the institutionalization of children and youth through community and home-based programs. These programs are the outcome of policy reforms incorporating the goals of family preservation and reflect a movement towards strength-based treatment paradigms incorporating ecological systems of care (Stroul & Goldman, 1990). The family preservation movement was based on the premise that children should grow up with their parents, that families could learn self-sufficiency, and that services should be community-based and provide permanency planning for families. For instance, the Juvenile Justice and Delinquency Prevention Act of 1974 (2019) set policy for runaways and curfew violations to be addressed in the community as an alternative to institutionalization. The Adoption Assistance and Child Welfare Reform Act of 1980 (2019) set guidelines for states to establish prevention and reunification programs in foster care, while making reasonable efforts to prevent a child's placement out of the home. The Child and Adolescent Service System Program (CASSP), as described by Stroul and Friedman (1986, pp. i - v), promoted an integrated system of care for

seriously emotionally disturbed children incorporating wrap-around and home-based services.

CASSP provided the theoretical basis for the Children's Mental Health Initiative (CMHI), which in 1993 initiated funding to the states to establish services for at-risk children (0-21) with serious emotional disturbance (DHHS, 2010). Currently funding is provided nationally, including in US territories, on a graduated matching basis with the goal of states and territories assuming a greater proportion of the costs over time. Starting in 2005, additional 5-year grants were released to nine states through the Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration program to determine the cost effectiveness and efficacy of home and community-based services as alternatives to institutionalization; at the end of the grants, states were eligible for Medicaid waivers to continue services for clients admitted to the programs, but had to find alternative funding if they wanted to admit new clients (Urdapilleta et. al., 2012). A review of the reports and the corresponding legislation reveals a web of regulations and restrictions that agencies have to comply with in order to meet funding criteria; changes at either the federal or state level can have a critical impact on program sustainability.

Target population. These programs targeted children who were manifesting problems in the home, school, and community environments, and required the involvement of multiple systems besides mental health, such as special education, child welfare, vocational, health, and juvenile justice services (DHHS, 2010; Stroul & Friedman, 1986). The families involved in HBFT are often described in the literature as multi-problem families (Adams & Maynard, 2000; Woodford, 1999), although Madsen (2007) argues that multi-stressed more accurately reflects their situation. Stressors the youth and families may be dealing with include mental illness, truancy, school and/or employment issues, family and/or community violence, substance abuse,

chronic illness, immigration, housing, or financial concerns (DHHS, 2010). Many of these families have had previous engagement with either child protective services or juvenile justice and other service providers and HBFT has been considered as a last resort before institutionalization (Woodford, 1999). HBFT programs were developed to engage families in addressing the issues that led to the referral by the child welfare and juvenile justice systems and have been designed to “maximally empower families to use their own families and contextual resources to resolve a major, often life-threatening...crisis” (Seelig, Goldman-Hall, & Jerrell, 1992, p. 135).

Program evaluation. There is a body of effectiveness research on HBFT, ranging from evaluation of small agency pilot programs to government-funded randomized clinical trials of treatment models. In the last few decades, outcome research of family-based treatment models frequently used in HBFT programs that target specific populations, for example delinquent or substance-abusing youth, has demonstrated positive outcomes (Henggeler & Sheidow, 2012; Waldron & Turner, 2008). Findings from the PRTF Demonstration program found that overall, children and youth “either maintained or improved their functional status” as a result of home and community-based services (Urdapilleta et. al., 2012, p. 36), however, not all the programs studied were HBFT by definition. A meta-analysis of 37 efficacy studies has identified common program elements “associated with effective placement prevention” (Lee, et al., 2014, p. 252) and other studies have shown that home-based family interventions were effective in reducing overall treatment costs (Crane, Hillin, & Jakubowski, 2005; Urdapilleta et. al., 2012). The results of efficacy studies are promising, however, due to the heterogeneity of HBFT the studies are not generalizable to HBFT as whole.

Call for professionalization of HBFT. A recurring theme in the theoretical literature

over the past three decades has been the call for the legitimization of HBFT as a practice domain requiring specialized skills and knowledge as a matter of social justice (Cortes, 2004; Hammond & Czynszon, 2014; Woodford, 1999; Woods, 1988). These authors sought to distinguish HBFT from traditional mental health or family therapy services by highlighting the advantages and challenges presented by working with multi-stressed, at-risk, and underserved populations in their homes. They made the point that HBFT therapists had reported a lack of adequate training and supervision in the necessary skills to provide HBFT effectively. In part, this might be attributed to the therapists' educational background: as HBFT was being introduced in the 1980's, a typical home-based therapist was "a master's level clinician with experience in crisis intervention, individual counseling, and protective services" who needed an introduction to structural and systemic models in order to work with families (Zarski et al., 1988, p. 55).

The ongoing deficit in specialized training in HBFT continues to be demonstrated in the literature as well as in practice. It has been frequently noted by researchers that university training programs have been focused on developing clinic-based skills and competent therapists have often found themselves underprepared for the unique issues that come up in the home (Christensen, 1995; Stinchfield, 2004; Woodford, Bordeau, & Alderfer, 2006). In a multi-disciplinary study of home-based practitioners including marriage and family therapists, 50% of the participants identified a need for specialized training and 83.9% reported that they had no specific training in HBFT at all (Worth & Blow, 2010). In another study of licensed therapists obtaining certification to be eligible for Medicaid reimbursement of HBFT services, 71% reported never having received any formal training in home-based family therapy (McWey, Humphreys, & Pazdera, 2011). A recent unpublished survey of MFT training programs found that only 39% addressed in-home therapy in coursework and supervision with an additional 27%

addressing it only in supervision (Karam, Sterrett, & Lyness, n.d.).

Graduate institutions are not solely responsible for HBFT-specific training and supervision. The context of the agency setting is also critical to implementation of HBFT programs, but this has been much less frequently addressed in the literature. Agencies offering HBFT need to be “program knowledgeable and supportive” (Seelig et al., 1992, p. 148). This includes providing “rigorous staff training, intensive supervision and consultation.” (Seelig et al., 1992, p.148). Some home-based family models, like multi-systemic therapy (MST) and functional family therapy (FFT) have been offered to agencies on a contractual basis with inbuilt procedures for ongoing training and supervision to maintain fidelity (Henggeler & Sheidow, 2012). However, many agencies have developed or adopted HBFT programs without implementing the same degree of support (Henggeler & Sheidow, 2012).

Conflicts that arise between agency policy and therapists’ need for practice flexibility have contributed to therapist stress (Tate et al., 2014). The organizational climate, including the handling of role clarity, cooperation, growth, role overload, and role conflict, has been associated with employee attitudes and burnout (Green, Albanese, Shapiro, & Aarons, 2014). In a number of studies, inadequate supervision of agency employees has been noted as particularly problematic considering the number of ethical issues that are inherent in HBFT (Lauka, Remley, & Ward, 2013; Lawson & Foster, 2005; Roberts, 2006). In one survey, 12.9% of clinicians did not receive supervision as it was either not required or provided by their agency (Culbreth et al., 2004). Supervisees expressed a preference for using supervisory time to focus on the team climate, clinical skills, and self-of-the-therapist concerns rather than agency policies, and indicated that more time could be spent addressing the ethical and legal issues encountered (Culbreth et al., 2004).

Furthermore, despite the skill demands, HBFT generally has been an entry-level job for graduates (Worth & Blow, 2010). A cross-disciplinary study found that nearly 74% of participants had less than five-years' experience in HBFT and more than half (55.9%) had less than five years of work experience in mental health (Culbreth et al., 2004). In other studies reporting on experience levels, 60% of participants have been in the profession for less than five years (Roberts, 2006), or, the mean years in HBFT practice has been 3.03 years (Lawson & Foster, 2005). In some cases paraprofessionals have worked their way into the position; Lawson and Foster noted that only 63% of their home-based family therapists had graduate level training. In a later study of MST therapists, only 85% had graduate-level training (Glebova, Foster, Cunningham, Brennan, & Whitmore, 2011). Evidently, it is not uncommon for there to be a range of professional training and experience levels reflected in the settings employing in-home therapists, with clinicians frequently receiving supervision from a clinician licensed in another field, however there has been little discussion of whether this may contribute to lack of clarity around professional ethical codes and professional identity.

Therapist competencies and therapist role. There are several texts available that explain in detail the requisite skills, principles and practices of implementing specific HBFT models (see Alexander, Waldron, Robbins, & Neeb, 2013; Berg, 1994; Boyd-Franklin & Bry, 2000; Lindblad-Goldberg, Dore, & Stern, 1998; Swenson, Henggeler, Taylor, & Addison, 2005). Notably, these texts are focused on interventions and devote limited attention (if any) to the ethical challenges mentioned in HBFT research. In contrast, the qualitative research studies that provide therapists' perspectives from working in the trenches have collectively raised practice issues that have not been adequately addressed by proponents of HBFT models. For instance, it is taken for granted that in HBFT therapists are prepared to take a more active role in reaching

out to families, community members, and larger systems while maintaining appropriate levels of confidentiality (Boyd-Franklin & Bry, 2000) and that the associated ethical and legal challenges have been inherent training issues in HBFT (Zarski et al., 1988). However, qualitative studies of therapists' perspectives indicate that many HBFT therapists experience role related issues as a significant practice concern. The challenge of defining and maintaining professional roles when working with clients and larger systems—with the associated skills of joining, boundary setting, and confidentiality—has emerged as a recurring theme in the HBFT literature on therapist competencies, training, supervision, and ethics.

Christensen's (1995) qualitative study was the first to identify the need for specialized training and supervision to assist therapists in effectively utilizing the home environment, handle safety issues, manage role and boundary challenges, as well as be effective with clients.

Christensen set a critical tone that has been echoed in subsequent studies: Therapists' doubts of their effectiveness with mandated clients in the home environment led Christensen to raise the question whether the services were meeting the therapeutic goals of HBFT. A similar theme was found in Adams and Maynard's (2000) study conducted with two MFT focus groups in a university training setting which came up with eight knowledge domains important to HBFT: crisis and safety issues, the needs of multi-problem families, sexual abuse, single parents issues, substance abuse, severe mental illness, and adolescent development. The participants were generally satisfied with the program training in these domains; however, they were surprised by high levels of therapist demoralization reflecting both uncertainty about their role with larger systems and questioning whether they were "doing therapy" (Adams & Maynard, 2000, p. 47). This issue of whether one is doing therapy, along with anxiety about professional roles and boundaries, has occurred elsewhere in the MFT literature on therapists in training (Jager et al.,

2009; Snyder & McCollum, 1999; Thomas et al., 1999).

Role and boundary management has been defined as a practice competency by clinicians in the field as well. One aspect of this was to understand the dimensions of the therapist role as a member of a multi-disciplinary team (Adams & Maynard, 2000; Quinones, 2013), which included case management, advocacy, education, and mandated reporting (Cortes, 2004; Hammond & Czyszczon, 2014). In a heuristic study of counselors' perspectives on HBFT competencies utilizing interviews and a focus group, Stinchfield (2004) concluded that counselors needed to be aware of how HBFT differed from office therapy to successfully work with families in the home, but needed specialized training to do this well. Stinchfield also found that home-based counselors required the skill of being able to engage in multiple levels of joining—with the family, the community, and the other professionals involved with the family—while being mindful of their role in the context of the larger systems in order to maintain both therapeutic and professional alliances. Stinchfield's results reflected the broader meaning of "reaching out" (Boyd-Franklin & Bry, 2000, p. 6), but the study stopped short of exploring how counselors manage these demands.

In another exploratory study of in-home counseling competencies utilizing a focus group of experienced counselors and three field observations, Tate, Lopez, Fox, Love and McKinney (2014) had categorized role related competencies as *counseling behaviors*: namely, forming and maintaining effective professional and therapeutic relationships, skillfully collaborating within and across disciplines, and advocating for families' needs with larger systems. From a developmental perspective, the skills of joining, managing multiple relationships, boundary setting as well as feelings of ineffectiveness in the face of multiple challenges are associated with therapist ego development (Lawson & Foster, 2005). Drawing on Lawson and Foster's study,

Tate et al. emphasized the importance of focused supervision to support counselors working within the scope of their professional competence.

Quinones' (2013) phenomenological study of therapists' perspectives of HBFT practices and families presented a more positive picture of the profession, possibly reflecting the sample restriction to therapists with more than five years' experience post-licensure. Like many of the previous studies, therapist roles are not the primary topic under scrutiny, but can be extrapolated from the descriptions. According to Quinones, therapists needed to be able to move flexibly between the roles of therapist, community resource manager, and educator, as well as collaborator with other service providers, while managing their role as a guest in the client's home. At the same time, therapists needed to differentiate their roles from that of the paraprofessional team-members working with them (Quinones, 2013). Key qualities of home-based family therapists were flexibility, building rapport, boundary management (between themselves and members of the family), and accountability to clients, members of the treatment team, supervisors, and outside agencies (Quinones, 2013). The dynamics of working in a team and the effect of the team dynamics on the therapeutic relationship have not been explored in the literature.

Ethics in HBFT. In each of the studies cited in the previous section, the researchers raised ethical concerns with varying degrees of specificity. In the HBFT literature, the ethical principles of beneficence, non-maleficence, and autonomy underscored the discourse rather than specific ethical codes. The common theme of meeting the training and supervision needs of therapists was identified as a primary ethical concern in order to benefit the client and not cause harm (Christensen, 1995; Cortes, 2004; Hammond & Czyszczon, 2014). Studies have illustrated Boyd-Franklin and Bry's (2000) assertion that working in the home, the schools, and the

community presented complex challenges with maintaining confidentiality that are not typically encountered in office-based settings. In HBFT, informed consent has to take into account the challenges of managing confidentiality with collaborating professionals on the team, around extended family and visitors (Snyder & McCollum, 1999; Thomas et al., 1999), or the role as mandated reporters (Adams & Maynard, 2000; Christensen, 1995; Jager et al., 2009). Jager et al. also mentioned encountering conflicting interests between advocating for clients and maintaining therapist's alliances with child welfare agencies as third-party payers. Multiple studies have remarked on the increased levels of familiarity which occurred in the home where the therapist was in the role of a guest, leading to cultural dilemmas and boundary crossings (Snyder & McCollum, 1999; Stinchfield, 2004; Thomas et al., 1999). Overall, therapists reported managing the role and boundary issues in HBFT as challenges that adversely affected their work.

The dissertations that address therapist perspectives on HBFT raise comparable ethical issues. In a qualitative study of therapists' experiences providing HBFT to voluntary clients (all had experience with mandated clients as well), Martel (2008) interviewed clinicians with different professional backgrounds including marriage and family therapy: the clinicians all reported ethical issues and feeling concerned that there were no clear ethical guidelines for home-based work. Specific concerns included confidentiality, boundaries, informed consent, and lack of training or guidelines for HBFT practices. In the study, one participant raised the question of whether it was ethical to practice in the home, echoing questions previously brought up in Christensen's (1995) study. In contrast, Quinones (2013) provides a more nuanced presentation of ethical concerns, illustrating the role taken by therapists in setting boundaries that match their comfort level and ethical understanding. In addition to confidentiality and boundary concerns, Quinones defined cultural sensitivity when working in the home as a competency of

ethical importance. Professionalism in billing and time management was also cited as an area of ethical accountability that has not been raised elsewhere (Quinones, 2013).

Three studies of home-based therapist's attitudes toward the ethical situations that arise in HBFT have been conducted using survey methodologies (Lauka et al., 2013; Roberts, 2006; Worth & Blow, 2010). Roberts (2006) used purposive sampling to recruit participants from agencies that offered in-home MST and outpatient services; participants were provided a survey designed to measure the ethical dimensions of confidentiality, role confusion, client diffusion (attending to non-identified client issues), and unintentional witnessing using proxy measures. Roberts used a multivariate analysis to compare in-home and outpatient therapists with regard to education, experience, and supervision experience against these dimensions. He found that in-home therapists reported a higher frequency of violations of confidentiality and role confusion, with client diffusion reaching near statistical significance. A finding of significant concern was that home-based therapists received significantly less individual supervision than their office-based counterparts and participants reported withholding information from their supervisor significantly more frequently; likewise home-based family therapists were less likely to be state-licensed (Roberts, 2006). Roberts suggested that role confusion and boundary violations may be greater in the absence of ethics training and the license credential.

Lauka et al. (2013) drew upon Roberts' dissertation and the literature to develop a new survey instrument to measure attitudes towards ethical situations that was administered to participants recruited from agencies in-home and outpatient services. There were no statistical differences between in-home and outpatient therapists: both groups of therapists endorsed most of the situations pertaining to boundaries and confidentiality that commonly occurred in HBFT practice as unethical (Lauka et al., 2013). The researchers investigated whether the ratio of

counseling to case management was predictive of attitudes towards ethical situations: The difference between the two groups was only significant when the ratio of case management to counseling was 75% to 25%, highlighting the challenge in integrating the different ethics and boundaries of two separate helping modalities (Lauka et al., 2013). At the same time, although a greater proportion of participants in Lauka's study were licensed than in Roberts' (2006) study, there was a mixed response to the question whether therapists should belong to professional organizations that oversee ethical behaviors.

Recognizing that the practice of HBFT is professionally eclectic, Worth and Blow (2010) recruited a representative sample of licensed participants from the professional organizations for marriage and family therapists, social work, and mental health counselors to complete a survey of attitudes and clinical experience in HBFT. Worth and Blow reported that differences in attitudes towards therapeutic alliance, role delineation, and safety were relative to degree of experience in the field, however 82% of the participants had less than ten years of experience in home-based practice. Participants were invited to write in ethical challenges encountered which highlighted concerns with confidentiality, boundary violations, responding to living conditions, duty to warn, safety, managing conflicting interests of service providers, as well as lack of clarity around "Who is the client?" (Worth & Blow, 2010, p. 471). The results of this study reflected similar ethical challenges as reported by home-based clinicians in other studies and case-reports, leading the researchers to recommend that further research was needed to investigate how home-based therapists manage appropriate boundaries in the home environment (Worth & Blow, 2010).

Summary

Although the practice of HBFT spans over more than three decades, there has been

ongoing discussion of the skills and competencies necessary for ethical practice and social justice, and there remains a lack of clarity on these issues. In this discourse, HBFT clients are described as multi-stressed and multi-problem families and HBFT therapists are frequently depicted as underserved with respect to the training and supervision needed to work effectively with these clients. Whether discussing competencies, training, ethical issues, or supervision, greater clarity around professional roles and therapist-client boundaries emerges as a practice issue of importance. Managing multiple roles, professional boundaries, and confidentiality are inherent challenges in HBFT that evoke anxiety about ethical practice; however, there has been insufficient research into how therapists manage these challenges. At the same time, the concerns about the multiple roles and boundaries that are inherent in HBFT practice have not been examined in light of the ethical codes. In the following section, in addition to reviewing examples in the literature on managing unavoidable non-sexual multiple relationships, I will briefly outline two main threads in the debate and examine how the prevailing discourses on multiple (professional) roles in therapist-client relationships have been reflected in the American Association for Marriage and Family Therapy (AAMFT) ethical codes over time.

Ethical Discourses on Professional Roles

During the same period that HBFT was being adopted as a promising treatment approach, there was a heated discourse on multiple relationships (or roles) and professional boundaries within the mental health professions of marriage and family therapy, counseling and psychology. This debate emerged in the context of a changing landscape in mental health delivery, including systemic approaches to mental health treatment that presented challenges to ethical codes based on individualistic, psychoanalytic traditions. Contributing to the conversation, feminist therapists brought attention to power imbalances in the therapeutic relationship and explored ways to parse

out unnecessary trappings of the traditional therapist role from ethical practice (Brown, 1991). MFT and feminist theories provided a different perspective on the therapist-client relationship and therapeutic practices, raising the question whether the definition of ethical boundary setting and dual relationships should take into account the theoretical approach (Brown 1991; Hill & Mamalakis, 2001). Apart from prohibitions against sexual relationships, there was a lack of definitional clarity across the professions regarding boundary setting in non-sexual multiple relationships. In a study of ethical dilemmas encountered by participants in the previous year, confidentiality and “blurred, dual, or conflictual relationships” were the first and second most frequently experienced ethical situations (Pope & Vetter, 1992, p. 42), echoing some of the common issues raised in HBFT practice.

Debating multiple relationships. Originally referred to as dual relationships, the concept of multiple relationships has been applied to three distinct areas of overlapping roles with current or former clients: (a) romantic or sexual relationships, (b) non-professional relationships, and (c) additional professional roles (Cottone, 2010). Sonne (1994) defined multiple relationships as arising in situations where, either concurrently or consecutively, a therapist is “in more than one professional relationship” or is “in a professional role and another definitive and intended role” with a client (p. 336). Sonne’s examples of professional roles were specific, including therapist, supervisor, educator, researcher, forensic evaluator, expert witness, or employer; whereas her list of non-professional roles referred to the general categories of personal, social or business relationships. Professional roles have boundaries to be maintained: Professional boundaries are considered to contain the expectations and responsibilities associated with the professional relationship as well as the individual roles of therapist and client (Sonne, 1994). Transgressions of professional boundaries have been categorized as either boundary crossings, which are

considered therapeutically benign or beneficial, or boundary violations, which may be exploitative or harmful to the client (Gutheil & Gabbard, 1998). In the literature, distinctions between roles and boundaries are often conflated without making this distinction between boundary crossings and boundary violations; for example, social gestures associated with culturally-based friendship norms may be treated as equivalent to the proscribed role of friend. Ethical confusion arises when an ethical code offers ambiguous proscriptions of multiple relationships instead of defining unethical relationships (Sonne, 1994).

The fundamental concern with multiple relationships is the potential of harm or exploitation of the client. Kitchner (1988) has proposed that all multiple relationships are potentially problematic. Citing role theory, Kitchner argues that roles are associated with specific expectations and that conflicts may arise between competing roles expectations, potentially leading to privileging one role over the other. According to Kitchner, the potential to cause harm is three-fold:

First, as the incompatibility of expectations increases between roles, so will the potential for misunderstanding and harm.... Second, as the obligations of different roles diverge, the potential for divided loyalties and loss of objectivity increases.... Last, as the power and prestige between the professional's and consumer's roles increase so does the potential for exploitation and an inability on the part of the consumers to remain objective about their own best interests. (p. 219)

Consequently it is incumbent on therapists to be aware of the expectations associated with the roles they enter into and to clarify their role obligations with clients; where there are multiple relationships, it is incumbent on therapists to take steps to protect clients from harm and address any problems that might arise (Kitchner, 1988).

A preponderance of the literature on multiple roles has focused on the risk of harm to the client when there is a crossover between personal and professional roles anticipating the slippery slope to developing sexual relationships. Borys and Pope's (1989) survey of attitudes and practices of professionals towards boundary crossings and dual professional roles supported this perspective. Borys and Pope found that participant's rating of the ethicality of dual roles varied significantly by gender, experience, practice locale (e.g. rural) and theoretical orientation. Borys and Pope suggested that their findings on the prevalence of therapist's non-sexual multiple relationships indicated that male therapists were more likely to consider dual professional roles and social or financial boundary crossings as ethical, and more frequently engaged in these activities with female clients. Pope (1991) argued that allowing social, financial or professional dual relationships would adversely alter the boundaries of the therapeutic relationship leading to an erosion of the therapeutic role, creating conflicts of interest, and undermining the cognitive processes of psychotherapy. While the slippery slope argument has not been a feature in the HBFT literature, therapists have reported that increased familiarity in the guest role challenged their perception of their efficacy in the therapeutic relationship (Snyder & McCollum, 1999; Stinchfield, 2004; Thomas et al., 1999).

By the 1990's many professionals had begun to challenge blanket assumptions that all multiple relationships are harmful or that non-sexual multiple roles necessarily led to (sexual) exploitation (Ryder & Hepworth, 1990; Zur & Lazarus, 2002). Proponents argued that consideration of non-sexual multiple relationships should take into account the context of the therapeutic relationship, cultural considerations, the therapy model, and the potential for familiarity to enhance the therapeutic relationship (Zur & Lazarus, 2002). As well as challenging the syllogism that boundary crossings led to boundary violations, or that power was necessarily

exploitative, Zur and Lazarus (2002) questioned whether the rules of psychoanalysis, for example handling transference through anonymity, should be applied to other therapeutic modalities through the ethical code. In a critique of the broad proscription of dual relationships in the 1988 AAMFT ethical code, Ryder and Hepworth (1990) argued for preparing clinicians to embrace relational complexity instead of “legislat(ing) simplicity into relationships” (p. 131). While dual roles introduced complexity to the client-therapist relationship, they also enhanced “human connectedness...[and were] more likely to be affirming, reassuring, and enriching, than exploitative” (Tomm, 2002, p. 32). The real issue, according to Tomm (2002), was the misuse of power in the professional relationship and types of exploitation that can occur.

Multiple relationships in the AAMFT Code of Ethics. Reference to dual relationships first appeared in the 6th American Association of Marriage and Family Therapy ([AAMFT], 1985) *Code of Ethical Principles for Marriage and Family Therapists*, as an expansion of Principle 1.2 that prohibited sexual intimacy with clients. In the 2015 revision of the AAMFT ethical code multiple relationships are addressed in Standard 1.3:

Marriage and family therapists are cognizant of their potentially influential position with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client’s immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken. (American Association of Marriage and Family Therapy [AAMFT], 2015, “1.3 Multiple Relationships” para. 1)

The opening statement of Standard 1.3 was first introduced in 1985, recognizing the relational dynamics of the therapeutic relationship and implying the principle of nonmaleficence in justifying the prohibitions that followed: “Marriage and family therapists therefore make every effort to avoid dual relationships with clients that could impair their professional judgement (sic) or increase the risk of exploitation” (AAMFT, 1985).

The American Association of Marriage and Family Therapy ([AAMFT], 2001) *Code of Ethics* has been critiqued for its lack of definitional clarity (Cottone, 2005; Tomm, 2002). In the 2001 revision “conditions and multiple relationships” had replaced “dual relationships”, however, conditions was a vague contextual term that did not add clarity to what had to be avoided (AAMFT, 2001). Briefly, the 1991 code had placed the responsibility to monitor behaviors, instead of simply avoiding situations, squarely on therapists’ shoulders: “When a dual relationship cannot be avoided, therapists take appropriate professional precautions to ensure judgment is not impaired and no exploitation occurs” (American Association of Marriage and Family Therapy [AAMFT], 1991); however, this sentence was removed in the 2001 code and replaced with “When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions”, resituating the problem in the role instead of in therapist behaviors (AAMFT, 2001). Cottone (2005) had previously argued that the fundamental principle of doing no harm was inadequately addressed by defining problematic multiple relationships on the basis of potential exploitation and impaired judgment. Critics have also argued that the emphasis on duality obfuscates the problem of exploitation (Tomm, 2002). The current definition of multiple relationships that “include, but are not limited to, business or close personal relationships with a client or the client’s immediate family” remains open-ended and does not address whether multiple professional roles are considered problematic (AAMFT,

2015).

Prohibited dual roles. The 2001 revisions created separate standards for prohibited dual relationships: two that addressed proscriptions on sexual intimacy (Principle 1.4 and 1.5) and one that prohibited combining a therapeutic role with forensic evaluations in custody cases (Principle 3.14; AAMFT, 2001). In the 2015 revisions, the latter was included in a set of legal standards addressing dual roles and conflicts of interests. Standard 7.7 remains aligned with Principle 3.14 (AAMFT, 2001): “Marriage and family therapists avoid conflicts of interest in treating minors or adults involved in custody or visitation actions by not performing forensic evaluations for custody, residence, or visitation of the minor.” (AAMFT, 2015) However, a new standard, Standard 7.76, precedes it, which advised avoiding certain dual roles unless mandated otherwise, aptly titled Avoiding Dual Roles: “Marriage and family therapists avoid providing therapy to clients for whom the therapist has provided a forensic evaluation and avoid providing evaluations for those who are clients, unless *mandated by legal systems*” (emphasis added; AAMFT, 2015). For home-based family therapists working with juvenile justice, this lifted potential concerns of liability but does not resolve the ethical dilemma of doing no harm. Unlike the standard on multiple relationships, the 2015 standards for professional evaluations are more specific with respect to therapists’ responsibility to “clarify roles”, “disclose potential conflicts”, and inform clients of “the extent of confidentiality” (Standard 7.5; AAMFT, 2015).

Managing unavoidable non-sexual multiple relationships. There are a number of settings besides HBFT where multiple relationships are considered inherent and unavoidable, including LGBT and other minority communities (Brown, 1991; Kessler & Waehler, 2005), rural and religious communities (Gonyea, Wright, & Earl-Kulkosky, 2014; Hill & Mamalakis, 2001), rehabilitation (Cottone, 2010), marriage and family training programs (Russell & Peterson, 1998;

Ryder & Hepworth, 1990), forensic services (Woody, 2009; Ward 2013), and military settings (Johnson, 1995; Norton & Soloski, 2015). While this list is not exhaustive, the literature illustrates the spectrum of multiple relationship concerns, from overlapping personal and professional identities that occur in community and social environments to professional role conflicts experienced in the employment arena. However, research on managing non-sexual multiple relationships is very limited. The majority of the authors listed above provide commentary on the contextual role dilemmas and propose tailored decision-making strategies for evaluating and handling entering into dual relationships with clients. While the stated first concern is avoiding exploitation or harm to the client, minimizing risk to the practitioner underscores each step.

Small communities. The literature on multiple relationships in small communities is primarily concerned with social and business relationships. As multiple relationships are inevitable in small communities there was a shared concern that therapists who sought to avoid non-therapeutic encounters altogether were at risk of therapist isolation (Brown, 1991; Gonyea et al., 2014; Hill & Mamalakis, 2001; Kessler & Waehler, 2005). Despite the preponderance of decision-making models offered in the literature to assist with deciding whether or not to engage in another relationship with a client, recent research on rural marriage and family therapists found that most therapists did not follow a specific model or obtain supervision (Gonyea et. al, 2014). Instead, they were more likely to rely on “professional judgment” (p. 6) to determine harm or benefit, taking into account the context and nature of the relationship, as part of the process of navigating dual roles (Gonyea et. al, 2014).

Employment contexts. Avoidance of multiple professional roles is generally not a choice in employment contexts where a professional’s job description encompasses multiple roles. The

demands and challenges of these work settings are context dependent, but the potential for harm may be amplified where there are greater differences in expectations, obligations, and power (Kitchner, 1988). The literature on multiple professional roles is limited. Settings where MFTs are likely to encounter multiple professional roles include employment in MFT training programs, the military, forensic settings, and HBFT.

MFT training programs. The AAMFT (2015) *Code of Ethics* has specific standards for dual roles with students and supervisees, but what differentiates the training setting from therapist-client contexts is that the power differential diminishes as therapists in training eventually progress into collegial positions. In marriage and family therapy training programs the professional MFT may be a teacher, supervisor, advisor and/or mentor to the therapist in training who may have other roles besides student, including supervisee, teaching or research assistant, or mentee. As gatekeepers, the teacher and supervisor hold a position of power that could be used to exploit the vulnerability of the student/supervisee (Russell & Peterson, 1998). Managing multiple roles in these situations requires on-going monitoring of boundaries and self-examination on the part of the person in power (Russell & Peterson, 1998; Tomm, 2002). Ryder and Hepworth (1990) argue that prohibiting multiple relationships in the academic setting would prevent students from learning how to manage them professionally.

Military and forensic settings. Military and forensic settings are two employment contexts where there is a greater power differential between therapist and client by virtue of the setting. In both arenas therapists may hold multiple role identities that have conflicting rules and expectations leading to conflicts of interest (Norton & Soloski, 2015; Ward 2013). For example, in the military, therapists have a dual allegiance to their employer, the Department of Defense (DOD), and to the profession (Johnson, 1995); army MFT chaplains have three distinct

identities—military officer, chaplain and therapist—each with different obligations to the laws and ethical codes (Norton & Soloski, 2015). Besides having to integrate these roles, military MFTs have to contend with differentials of power associated with rank and experience as well as a greater risk of counter-transference with fellow soldiers (Norton & Soloski, 2015). Similarly, therapists employed in forensic settings, for example prisons or mandated juvenile justice programs, have to balance at least two sets of norms and ethical codes: their forensic responsibility is to community protection and their therapeutic responsibility is to uphold the individual well-being of the client (Ward, 2013). Military and forensic therapists may experience a blurring of boundaries when called upon to do evaluations (Johnson, 1995; Ward, 2013). In these types of settings where their employment could be at stake, therapists may feel compromised by competing loyalties (Woody, 2009) or powerless to meet client needs (Norton & Soloski, 2015). Johnson and Wilson (1993) stated that therapists in these situations typically managed competing loyalties in one of three ways: (a) by adhering to the regulations and law, or (b) by following the professional code of ethics, or (c) compromising by choosing between the two on the basis of seems to be in the client's best interests. Ward (2013) proposed an aspirational multi-step collaborative model that was intended to locate shared norms between the competing value systems of all participants, however Ward did not report on the application of the model.

Multiple roles and HBFT. The distinction between roles in HBFT has been less clear-cut than it is in the military or academia. In their professional capacity, home-based family therapists may be required to don a variety of other “hats”—caseworker, educator, mandated reporter, advocate, evaluator, team member; depending on the position, they may be subject to pressures from third-party payers who may also be on the team. Each of these hats comes with associated

responsibilities, objectives, and accountability. Additionally, there are several areas of social concern that have come up for therapists in the context of HBFT: (a) working in the home can increase familiarity as they are in the dual role of guest; (b) there may be outside contact in the community they are working in; (c) in some contexts, it may be impossible not to work with families with overlapping relationships.

In the HBFT literature there are three studies that address managing multiple roles (Jager et al., 2009; Snyder & McCollum, 1999; Thomas et al., 1999). These MFT studies are notable as the only published examples of process-focused research in the HBFT literature on this topic. Reporting on a collaborative study conducted on two sites, Thomas et al. (1999) and Snyder and McCollum (1999) found that anxiety was reduced when therapists reformulated their conceptualization of therapy and the therapeutic relationship—redefining their understandings of boundaries, confidentiality, and timing, and developing strategies to manage roles. Jager et al. (2009) conceptualized the process of learning to manage role conflicts between advocacy and therapy when working in child welfare settings and other forms of role ambiguity as movement towards professional identity development. As all three studies were conducted with therapists in training, it is not surprising that managing conflicting roles in HBFT has been framed as a developmental process. The strategies used by the participants once they got past the first developmental reframe were not investigated. How this might look in the field where therapists are more likely to rely on professional judgment than supervision remains unexplored. Given that experienced HBFT professionals have reported ongoing struggles with role and boundary issues, there is a need to investigate how they manage multiple professional roles in greater depth.

Conclusion

In this literature review I have presented a brief overview of the context in which home-

based family therapists' practice. Although HBFT models are heterogeneous, the cross-disciplinary research has suggested that issues with roles, boundaries, and confidentiality are inherent in the field. Given the small body of research on HBFT, there has been a preponderance of studies that presented these role challenges as an ethical practice issue. Alternatively, researchers have suggested that role and boundary definitions have to be adjusted to fit the delivery model (Snyder & McCollum, 1999; Thomas et al., 1999). While there has been an abundance of aspirational models for managing multiple roles for different practice settings, the question remains how these may be utilized in practice, particularly as research on managing multiple professional roles is very sparse. Investigating how marriage and family therapists manage multiple professional roles in HBFT would be a step towards filling this gap. In the following section on the research method I will outline how I structured and executed this research project.

CHAPTER 3

Research Strategy

The Research Question

The research question that guided this study was: How do marriage and family therapists manage multiple professional roles in HBFT? Grounded theory is a methodology that is suited to questions like this that seek an explanation of actions or processes (Creswell, 2007). In the following sections I will discuss the rationale behind choosing a grounded theory approach and the decision to adopt Charmaz's (2014) constructivist approach before presenting the data sample, procedures and analysis.

Grounded Theory (GT) Methodology

When selecting a methodological framework to understand how marriage and family therapists manage their professional role(s) in home-based family therapy, I was looking for an approach which would support arriving at an understanding that was more substantive than the shared description of therapists' experiences that is found in the literature. While previous researchers have reported that home-based family therapists have a range of experiences pertaining to their role in the delivery of home-based services, including role confusion or diffusion, role identity, and boundary issues, the processes by which they resolve or respond to these issues have not been fully explicated. Grounded theory methodology offers a systematic analytical approach to derive theoretical explanation(s) of actions and processes from data (Charmaz, 2014; Glaser, 1992; Glaser & Strauss, 1967). The researcher seeks to understand the participants' situation and how they deal with particular challenges by developing an inductive theory (Glaser, 1992). Furthermore, this approach is suited to questions that call for a process of discovery, unfettered by prior theories. According to Glaser (1978), "the generative nature of

grounded theory opens up the mind of the analyst to a myriad of new possibilities” (p. 6).

Constructivist grounded theory. In the first methodological treatise on grounded theory, Glaser and Strauss (1967) direct researchers to develop theory from fundamental social processes grounded in qualitative data. They proposed a methodology of systemic analysis that could be used to construct abstract explanations of psychological and social processes. Despite parting ways in their later explications of the model (Glaser, 1992; Strauss & Corbin, 1990), their respective approaches to grounded theory have been associated with a modernist stance with objectivist assumptions of an external reality, assumptions of un-biased inquiry, and the premise that the data speaks for itself. Although Glaser and Strauss (1967) indicated that grounded theory is independent of epistemology, others have made explicit the underpinnings of pragmatism and symbolic interactionism that Strauss had brought to the model (Charmaz, 2014; Clarke, 2005; Corbin & Strauss, 2014). Charmaz (2008; 2016) traces the roots of constructivist grounded theory back to Glaser and Strauss’s (1967) original inductive approach to studying processes and participants’ perspectives. Recognition of relativity stands side by side with assumptions of objective neutrality: Glaser and Strauss note that researcher’s “theoretical formulations represent credible interpretations of data, which could, however, be interpreted differently by others” (p. 225), but at the same time assume that the researcher can be a detached observer. Addressing critiques of grounded theory as a modernist, positivist methodology, Charmaz (2008) makes a case for constructivist grounded theory: Trimming away objectivist principles and replacing them with their constructivist counterparts one can align Glaser and Strauss’s (1967) strategies with postmodern 21st century epistemologies.

As a researcher, I am critical of the notions of objectivity and neutrality. I come to this research with a postmodern perspective that research inevitably entails interpretation of meaning

and *situated knowledges* (Haraway, 1988, p. 581). Situated knowledge places knowledge in context and promotes the exchange of views to broaden perspective. I embrace the position, taken by Anderson and Goolishian (1991), that: “What is known is known through a perspective, an experience, and interpretation” (p. 22). This is at first glance contrary to the positivism of Glaser and Strauss (1967) that posits that grounded theory can offer an objective analysis grounded in the data, but is congruent with Charmaz’s (2008) constructivist and Clarke’s (2005) situational interpretative approach. I chose to follow the constructivist avenue of grounded theory as it acknowledges the relativist, perspectival, constructionist, and interpretative understandings of meaning making in context (Clarke, 2005). It also makes explicit the role of the researcher in recognizing that research is a social construction which requires ongoing reflexivity in their approach to methodology, analysis, and representing the participants’ perspectives (Charmaz, 2008).

Role of the researcher in constructivist grounded theory. In qualitative research the researcher plays a particular role as the instrument of data collection and analysis (Creswell, 2007). In interpreting the data, there is an inevitable shaping of the meanings provided by others, and that these interpretations, through the coding procedures, form part of the data that leads the way to theory. As written above, the constructivist grounded theory researcher seeks to maintain a position of ongoing reflexivity. Etherington (2004) defines this position as “the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid or changing) inform the process and outcomes of inquiry” (pp. 11-12).

Taking this into account, there are a number of procedures that I have incorporated in the research design to promote reflexivity to researcher bias or preconceptions. Firstly, using verbatim transcriptions instead of notes allowed me to monitor my role in co-constructing data

through questions and responses. I followed a protocol of coding procedures to scrutinize the data in new ways and using analytical memo writing to guide the research as recommended by Charmaz (2014). My coming into the research with experience in the field sensitized me to differences in perspectives; I kept a methodological journal to reflect on these differences, research challenges, and decisions which helped promote ideas to pursue in the analytical memos (Charmaz, 2014). This journal was also a place to privately reflect on my role as a researcher and my thoughts about the research as it was unfolding in order to foster awareness of thinking biases (Etherington, 2004).

Although I came to this research with experience in both HBFT and outpatient therapy and could identify with many of the challenges documented in the literature, my experience as a researcher was limited to classroom exercises in transcription and coding. To prepare for this study I attended an experiential workshop with Kathy Charmaz at the University of Pisa International Summer School that was focused on the pragmatics of sampling, interviewing, coding and theory development in constructivist grounded theory research; a day of the workshop with David Altheide addressed incorporating symbolic interactionism as an underlying theory. With respect to symbolic interactionism, I was sensitized to how exposure to this perspective supported some of the suppositions I hold about identity and action. Although not intentionally taken as a framework for coding, analysis of the initial codes reflected an emergence of role, expectations, identity and agency as organizing concepts.

Procedures

Approval for this research was obtained from the Antioch University Institutional Review Board (See Appendix B) and the research was conducted in compliance with the ethical standards for research set out in the *AAMFT Code of Ethics* (AAMFT, 2015). In recruiting

participants the researcher followed the standards of obtaining institutional approval, obtaining informed consent, and informing the participants of their rights. An informed consent form that addressed the purpose and procedures of the study, the voluntary nature of the research, and confidentiality was reviewed and signed by participants in the study prior to interviewing (see Appendix C).

Prior to the interview participants in the study were informed of the potential risks and benefits of the research and their rights as voluntary research subjects, including the right to discontinue the interview or withdraw from the study at any time. Participants were provided with a copy of the informed consent and numbers to contact in the event they had questions or concerns about the research process. Within the course of the interview participants were reminded that they could deflect any question they did not want to respond to.

Participants. For the scope of this dissertation research, participants for this grounded theory study were marriage and family therapists who have provided in-home family therapy as part of a HBFT program; in order to be eligible participants were required have at least six months experience in providing HBFT services. The minimal experience requirement ensured that participants had some supervised practice (training) in HBFT and an opportunity to experience a range of professional HBFT experiences. In order to be included in the research participants were required to have a degree or graduate specialization in marriage and family therapy and be licensed or identify as license-eligible as a marriage and family therapist.

The researcher recruited participants through distributing a letter of invitation at professional trainings and meetings, forwarding the invitation letter to local agency directors known to employ marriage and family therapists to share with employees, and posting an invitation on an MFT alumni Facebook page (see Appendix D). A packet with the invitation

letter, informed consent and demographic questionnaire was given (or sent) to potential participants for review prior to scheduling an interview.

Initially, purposive sampling was restricted to therapists who had been actively practicing HBFT in the last six months. The rationale for this restriction was that they would not be too distanced from the experience to reflect on their experience. In the first seven months of the research this requirement excluded at least eight potential participants who either had moved into outpatient outreach work or supervisory roles more than six months previously. As many of these candidates seemed to have more experience in the field I decided to seek an amendment to the IRB to have this criteria removed in order to provide access to potential participants with a broader experiential background (see IRB amendment letter in Appendix B).

Sampling. In grounded theory research the selection of participants and direction of investigation is determined by what emerges from the data in each interview. In order to focus on potential participants who had experience relevant to the stage and direction of the research I recruited a convenience sample through networking and selective snowball sampling. For example, the initial convenience sample yielded participants who practiced in settings that did not have a fixed intervention model or funding-contracts with child welfare services; in subsequent sampling participants were sought who worked in such settings in order to pursue in more depth some of the emerging categories for comparison. Subsequent data collection was informed by theoretical decisions in order to develop “analytic depth and precision” (Charmaz, 2014, p. 213). Glaser and Strauss (1967) define theoretical sampling as:

...the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. (p. 45)

The identification of participants who might assist in theoretical development was pursued through networking. Additionally, interview participants were invited to identify potential participants to join the study. This was less productive than hoped as only a few responded who met the MFT criteria for the study.

In grounded theory research it is not numbers, but the quality of the interview that determines the richness and depth of the data (Charmaz, 2014). Consequently, predicting sample size in grounded theory presents a challenge for researchers as the researcher selects participants based on the data and cannot be predetermined. Although attempts have been made to quantify the number of participants needed, Charmaz (2014) argues that smaller numbers are more likely to result in generating descriptive themes without gathering sufficient data to pursue avenues of comparative analysis of emergent categories. However, the utilization of other methods of data collection, such as review of documents and field observation, can add depth to a study relying on fewer participant interviews (Charmaz, 2014).

A total of 12 marriage and family therapists were interviewed for this study; seven of the 12 participants participated in follow-up conversations to expand theoretical themes that had emerged in the analysis. These conversations provided more depth and clarification to the data.

Data collection and management. Data was collected from participant interviews and a brief demographic survey that was completed by participants prior to the interview (Appendix E). In order to add depth to the study, additional data was gathered from unstructured field observations documented in field notes and public documents as described below.

Interviews. The primary source of data was intensive interviews with 12 marriage and family therapists who have provided home-based family therapy services. Charmaz (2014) defines intensive interviews as “a gently guided, one-sided conversation” (p. 56) utilizing open-

ended questions that focus on eliciting the participants' experience of the research topic. A sample of the exploratory questions can be seen in the initial interview guide (see Appendix F).

Interviews were conducted face to face or by video conferencing. Interviews were scheduled at a time and location convenient to the participants. Eight of the interviews were conducted face to face at a location chosen by the participant: three of the interviews took place in clinic offices, one at Antioch University, one in a participant's home, two in the researcher's home-office, and one at a conference hotel. The remaining four interviews were conducted by video conferencing. If the interview was conducted by video conferencing, the interview was scheduled after the informed consent and questionnaire had been completed. For in person interviews, these forms were completed prior to starting the recording. The initial interviews were recorded on a Sony ICD-UX533 and/or an iPod and took on average 66 minutes (ranging from 52 to 85 minutes). All participants received a \$25 gift certificate in consideration of their time.

In constructivist grounded theory a respectful, exploratory approach to emergent understandings of participant experiences is retained while focusing data collection on the rich development of theoretical categories (Charmaz, 2014). In order to gain participant perspectives on emerging categories, I spoke with seven of the 12 participants who were available for follow up conversations. Six of these conversations were conducted over the phone; one of these conversations was held face to face; conversations lasted from 20 – 50 minutes. I took notes during the conversations and wrote them up immediately afterwards for coding. Through this process of member checking and focused questions I was able to confirm and gather more information on emerging theoretical categories.

Field notes. Although intensive interviews constituted the primary data source, other forms of data, including observations and documents, were collected to further the develop categories. For example, I wrote field notes based on observations made in the interviews recording descriptive data that was not captured in the interview narratives, such as setting, interactions with the participant, and non-verbal communication.

Other unstructured observations without identifying information were gathered when visiting agencies offering HBFT services through the course of my work, including my own site of employment. In recognition that these impressions contributed to my perspective and experience, I documented my reflections on these unstructured observations in a journal and made note of when analytical memos drew on these observations.

Documents. Topical literature, once coded and analyzed, can contribute to the collected data (Charmaz, 2014). To contribute to a contextual understanding of MFT's professional roles in HBFT I have also utilized data from public written sources. These have included agency webpages and job descriptions, as well as public policy documents that pertain to professional expectations of HBFT therapists. I collected job postings for home-based family therapists over the duration of the research as well as from the agencies that the participants worked. A total of 50 job postings were included in the analysis, contributing to an understanding of employer expectations.

Process journal. In order to track each phase of the research, I kept a process journal. This journal reflected activities undertaken and the decisions that were made at each step of the research. Here I also recorded the challenges and questions that came up as I worked.

Data storage. In order to protect the research data, interview recordings were kept on a password protected recording device until the transcription was completed and reviewed for

accuracy; they were then transferred from the recording device to a password protected, encrypted dedicated external hard drive where they will be kept until the research is completed, at which point they will be destroyed. The transcriptions and other research data were stored on this dedicated hard drive as well.

In order to maintain confidentiality but retain ability to link data with identifying information for the purpose of follow-up interviews and/or member checking, I designated an alphanumeric ID for each participant to be used on data documents. Assigned IDs were kept in a dedicated log that linked the ID with participant name. In the reporting the results of this study, the ID will be simplified to participant and interview number in parentheses, for example, a quote from the first participant therapist's first interview will be labeled (01-1) and their second interview (01-2).

A locked file was maintained for the signed consent forms, participant-related documents, the hard-drive and flash-drive when not in use. Paper documents with identifying participant information, including consent forms, the ID log, and any correspondence, were scanned and kept in a dedicated encrypted file on the external hard-drive as well so that they could be accessed through the computer, but remain separate from the data file: The file containing participant identifying information was given a unique password. All paper documentation will be shredded on completion and final approval of the dissertation research.

Data analysis. Data analysis in grounded theory requires a systematic but non-linear approach: It is an inductive, iterative, comparative, and interactive process (Charmaz, 2014). Data collection and analysis was concurrent with the interview process, with analysis beginning after the first interview. Charmaz (2014) describes two stages of coding in constructivist grounded theory: (a) the initial phase of line-by-line coding, and (b) a second phase of focused

coding utilizing existing codes to organize and synthesize the data to develop categories. This process of analysis and synthesis is intended to raise categories to theoretical concepts that will constitute the grounded theory (Charmaz, 2014). In the following sections I will describe how I applied this coding paradigm to the data in this research.

Process overview. Grounded theory analysis is founded on asking questions of the data and developing codes to define what is happening in the data. At each stage of the analytic process, the researcher is called upon to ask: “What is this data a study of? What category does this incident indicate? What is actually happening in the data?” (Glaser, 1978, p. 57). Throughout the coding process, data is analyzed with a *constant comparative* approach to inform subsequent data selection and build analytic categories (Charmaz, 2014; Glaser & Strauss, 1967). Data is compared to data, incident-to-incident, code-to-code as the research moves through the levels of analysis.

Following this model the researcher documents the constant comparative process in memos. According to Charmaz (2014), in addition to their use as a tool for critical reflexivity, memos are used to track developing ideas, make explicit thoughts about the data, and articulate analytical concepts. Tentative theoretical categories that emerge in the analytical memos form the basis for subsequent data collection (Charmaz, 2014). Charmaz instructs that the process of sorting theoretical memos serves to integrate the emerging theoretical concepts and provides a foundation to writing up the research. With this process as a guide, I proceeded with data analysis from the initial interview to the sorting of memos and the documentation of the results.

Transcription and interpretation. Discussions of analysis usually begin with a description of the coding process. However, it can be argued that data analysis actually begins with the transcription of the interview. Transcription is the first level of interpretation where

decisions are made about what is included in the transcript (content) and how it is presented in written form (Bucholtz, 2000). When the researcher listens to the data they can identify emotional and non-verbal nuances to pursue further (K. Charmaz, personal communication, June 6, 2016). Initial interviews with each participant were audio-recorded with a digital recorder and transcribed verbatim for coding. Although transcribing data is highly time consuming, I transcribed the interviews myself in order to immerse myself in the data as well as the transcription process.

Prior to interviewing, I had created a transcription guide in order to structure the transcription process anticipating that some of these decisions would be revised in the course of the research (See Appendix G). Bucholtz (2000) differentiates between naturalized and denaturalized styles of transcription: Oliver, Serovitch and Mason (2005) describe the former as focused on the representation of the language as it is spoken (including accents and involuntary vocalizations) and the latter as attending to the substance of the interview. The focus on capturing the meaning and perceptions of the speakers in denaturalized transcription is compatible with grounded theory (Oliver et al., 2005). My transcription guide was closer to the denaturalized model, although initially I included non-verbal utterances and observable breathing patterns, as I was interested in capturing potential indicators of emotional stress. After the first interview changes made to the transcription guide were with respect to recording speech interruptions for the purpose of punctuation clarity. After the sixth interview I stopped transcribing response token crosstalk (e.g. hmhm, etc.) unless it significantly contributed to meaning. These changes are noted in bold on the transcription guide in Appendix G.

Initial coding. The initial coding was done line by line to establish open codes. The first pass in the open coding process provided 149 individual codes that were primarily descriptive of

what was happening. Charmaz (2014) recommends that the researcher stay close to the data in the initial coding by remaining focused on the actions. In Figure 3.1, the therapist, having previously identified having multiple roles and responsibilities, is responding to a follow up question: How compatible do you feel like your different roles were?

#001# 00:05:10	<p>//// (sigh) Uhm. (exhale) // I think sometimes it was a little challenging in the sense that families really needed more than just a therapist, they also needed a lot of case management and advocacy, um, so sometimes I find, I found myself not really getting into the therapeutic work that I might hope that I would get into in therapy, um and because in-home therapy is...we really worked at a crisis level, so um, sometimes I just did a lot of case management: kind of parenting skills, um coping skills and things like that and played more of an advocacy-slash-supportive role which, / which, which now that I am an outpatient I see is very, / it's very important, because now I am limited in outpatient, so that is one thing that I miss about doing community based.../ um, that I felt like I really got to be a little bit more effective in a lot more areas, because they are all so inter-connected [#SF# umhm] and effected by one and another. Um, so I'm not sure if this answers your question, but it certainly was.... I definitely felt a little bit limited doing the actual therapy work and I don't know if that was because of the time limitations, because you know, we really, in home therapy in the state of =StateA= was really only / meant to be for, um high-crisis families, so once children were stabilized then we kind of would sort of move towards termination. [#SF# umhm, umhm um (clears throat)] // I'm not s-[loss of connection]</p>	<p>Expressing stress response to different roles; finding it challenging Having to be more than 'just a therapist' -Assessing needs Identifying non-therapeutic roles: CM, advocacy Finding non-therapy roles displace therapy; feeling thwarted in therapeutic role Attributing role allocation to crisis Listing non-therapeutic roles -doing case management -providing skill training -being advocate/support Being in new role as outpatient therapist; making comparisons Valuing non-therapy roles Feeling limited in outpatient role Missing community-based work = ability to play multiple roles? Attributing broader effectiveness to multiple roles Taking a systemic perspective Feeling constraints on therapy Attributing constraints to time limitations Attributing constraints to state regulations Defining state objectives of IHT -Stabilizing families -Terminating services Expressing uncertainty</p>
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Figure 3.1 Extract from first interview illustrating open coding using Word document template.

The initial coding process involves fracturing the data in order to reveal underlying patterns (Glaser & Strauss, 1967). Charmaz (2014) proposes making use of gerunds in order to reveal the processes in these patterns. In the first round of coding I worked line by line, sticking closely to the data. I then read through the interview again with view to identifying larger segments of data that held meaning; these segments or incidents often represented processes or sequences of actions taken. With each subsequent interview the line-by-line codes and incident codes were examined for fit within existing codes or assigned new labels. This first pass at

coding provided a rich assembly of codes that was initially overwhelming; however, at this stage I wanted to remain open to all possibilities. As coding progressed, I became more focused on the similarities and differences between the codes and how they might come together.

Reviewing the codes from the first interview, I created thematic codes for the codes on the basis of my initial impression of action and purpose or type. For each code, I asked the question, “What is this data about?” These themes provided a structure for organizing the first pass; even as I started to move into more focused coding after the fourth interview I continued with the line-by-line coding. The thematic codes for the first pass are illustrated in Table 3.1.

Table 3.1

First Pass: Thematic Codes for Open Coding and Definitions

Thematic codes	Definitions
Managing role expectations	Actions taken in order to be effective in meeting role expectations
Naming challenges	Experiences of role-related discomfort in the workplace
Reflecting as a practitioner	Self-of-the-therapist processes as well as cognitive and affective responses to role experience
Understanding place in the system	Data relating to the setting, the job, and becoming an HBFT
Factors	Data concerning location, players, and qualifiers of time, frequency, duration

Under each of these thematic codes, the open codes were coded into related groups. To illustrate this, codes that were located under *naming challenges* in the first pass are itemized in Table 3.2. Initially, any event or action that therapists described as causing role strain was located under *naming challenges*; later in the research process, it became apparent that this categorization did not further understanding of the research question. Consequently, this

thematic grouping was shelved and therapist perceptions of their role experiences, positive and negative, were recoded and located under the theme of *reflecting as a practitioner*.

In the initial phase of the analysis I had been using a Word template for coding, however by the fourth interview I was finding it cumbersome to manage the evolving codes. In order to manage the data more easily, I utilized NVivo 11 software to facilitate the comparative process. I continued to return to the templates as a reference when revisiting the data. In the process of transferring data into NVivo 11, the data had to be recoded which provided an opportunity to look for consistencies and shifts in my initial interpretation of the data.

Table 3.2

Examples of Open Coding Groups

Naming challenges	Open coding examples
Labeling as ethical	handling confidentiality, receiving/giving gifts, holding secrets, protecting personal privacy, having dual relationships in community, handling fraudulent documentation, mandated reporting, (not) putting client needs first, setting boundaries
Lacking resources	lacking support, being inexperienced, finding community resources inadequate
Managing collaborative differences	conflicting clinical perspectives, feeling role conflict
Meeting job demands	complying with company mission/program rules, meeting productivity, being on call, managing safety, scheduling, traveling, blurring of work-life boundaries, complying with regulations, seeing isomorphism in organization, seeing high turnover, lacking role clarity
Meeting client demands	“Fix my kid”, lacking client trust, expressing service preference, blurring of role boundaries, client factors
Effecting personal life	being drained, having to drop everything, getting burnt out, straining personal relationships, (work)taking over life, feeling undercompensated financially, needing good boundaries

Constant comparative process. The process of comparing and questioning the data helped to consolidate the codes and reveal patterns in the data that could be pursued. In order to challenge potential preconceptions about the data Charmaz (2014) suggests asking questions of the data. This process of reviewing the initial codes and questioning the data also paves the way for the next phase of focused coding (Charmaz, 2014). I found the following questions derived from Charmaz most helpful with respect to my research question regarding managing professional roles: What process am I seeing here? What meaning does the research participant give to this process? What does the research participant's behavior (or meaning) suggest? What is the outcome? (p. 127). Asking questions of the data can result in coding the codes, thus moving them from a descriptive framework into an analytical frame (Charmaz, 2014). As I reviewed the coding I was sorting the labeled codes into like clusters that reflected actions, actors and meanings, as well as events, contexts and outcomes.

Focused coding. The second phase of coding begins as recurrent or significant codes occur; however, in constructivist grounded theory there is not a firm line drawn between the phases of coding. I continued to code the interviews line by line, but after the third interview I put my analytical attention largely on the codes that seemed to best address processes related to the research question. Charmaz (2014) suggests that the researcher approaches this analytically through constant comparison as described above in order to determine which codes best explain the processes observed in the data. The process of recursive questioning of the data invites analysis of the codes in the direction of developing categories and it is at this level of coding that one has the opportunity to move beyond descriptive summary to more analytical categories that reflect actions and processes (Charmaz, 2014). Charmaz (personal communication, June 8, 2016) encouraged researchers to treat the coding process as emergent by holding the focused codes as a

tentative step in the analysis that can lead the way to a higher level of analysis. The selection of codes to focus on was based on my determination of which processes seemed to best explain how therapists manage professional roles. Having these codes in mind contributed to the directions I pursued in the interviews, as I was curious about their usefulness and fit.

Through the comparative process, a recurring narrative of being professional and professional identity began to emerge and the open code *being professional* was elevated to a focused code. Likewise, as therapists presented their actions as the result of an ongoing learning process a focused code was created for *developing competencies* and *self-efficacy*. The process of coding, comparing, clarifying, and in some cases re-coding and setting aside old codes was documented in a journal as well as memos.

Category formation. The formation of categories arises from the constant comparative process and the analytical evaluation of focused codes (Charmaz, 2014). The comparative process occurred at the level of comparing participant responses to the same question, comparing participant experiences (incidences), and comparing code to code. The comparative process was documented through visual maps that were used as a tool to make connections between the different categories, in memos that discussed emerging ideas and reflected on new directions to take, and journal entries that tracked coding decisions and changes. In this manner of analysis I continued with coding the data, comparing codes, and pursuing emergent concepts.

Mapping. I made use of visual maps in order to explore relationships between different levels of codes. Figure 3.2 represents a conceptualization of codes of interest mid-way in the research as I was exploring the categories associated with the tentative themes *being professional* and *managing professional roles*, and how these intersected with codes in *reflecting as a practitioner*. Mapping provided an opportunity to question existing coding relationships,

particularly when they do not flow on the page; likewise, mapping often suggested new code groupings.



Figure 3.2 Example of mapping early coding as a tool to explore emerging relationships

On the basis of this mapping exercise a new thematic grouping focused on therapist reflections on role and identity provisionally labeled *monitoring professional persona* (later

maintaining professional identity) was created to bring together therapists' self-reflection on professional identity. Multiple iterations of this map led to defining the agentic practices that are reported in the final results of this study.

Memo writing. Concurrently with coding memos, I wrote memos reflecting on the emerging categories, their properties, and theoretical directions to pursue. Developing a theory grounded in the data requires focusing on processes instead of individuals, by asking "analytic questions of the data" (Charmaz, 2014, p. 247). In the following reflective memo written after comparing therapist reports on handling ethical challenges, I decide to look further at the therapists' affective response to situations with a focus on role congruity and dissonance.

Interview question: To what extent have you considered any of the role and boundary related situations you have experienced in home-based family therapy as an ethical issue?

A shared response to this question was that an ethical situation was most commonly associated with some experience of discomfort or stress (role strain?), to which the therapist undertook some action to address the situation. In many instances, in discourse, the therapist poses a seemingly rhetorical question, "How do you manage that?" or "Huh! (chuckling) What was that about?" Here we are introduced to an internal reflection on what to do, or a report of an external consultation with others to find a satisfactory course of action. In this dialogic exchange we learn about their values, experience, and knowledge as they provide a rationale for action. In many examples, the therapist reveals an appraisal of personal efficacy, sometimes self-qualified by their stage of learning HBFT at the time of the experience. In accounting for how they handled the situation, there is a detectable tone of congruence or incongruence with the outcome.

Follow up: Outside of the response to this question, do experience scenarios provide other examples of congruity and incongruity to compare? How do these tie in with therapist's reports of self-confidence and self-efficacy?

This memo on ethical experiences documented a shift in thinking away from the content of events towards a more theoretical conception of therapists' experience; it would later be linked to the focused codes *reflective practices* and *communicative practices*. Additionally, in this example of the evolution of the thematic codes, the tentative theme of *naming challenges* was compared with contextualizing scenarios resulting in a new focused code labeled *having role experiences*. This enabled me to look at all events in terms of therapist perception instead of categorizing them by event type as illustrated in Table 3.2. This analysis yielded a different grouping of codes concerned with identity, perception, and behaviors that related to how therapists developed competency and experienced self-efficacy in their work as a HBFT.

Journaling. The journaling process was used to document decisions made in the coding process as well as my own personal reflections on the research. I kept three journals: one was a scratch-book where I documented comparisons which were later written into memos; the second was a record of coding activities in NVivo (including coding deliberations, data crashes and associated despair); the third journal contained personal reflections on process and exploration of the relationship between the data and existing theories that might inform the development of theoretical categories. The journaling process led to further development of memos and new coding directions.

Theory development. By the mid-phase of the research the picture that was beginning to emerge was one of professionals who, through experiential learning and grounding in their own tacit knowledge, were able to actively perform certain actions that were conducive to managing

their professional roles, experiencing self-confidence (or lack of) in doing so. Charmaz (2014) considers theorizing a practice of exploring how participants interpret meaning and actions. The themes that were coming to the forefront in the comparative, analytical process were concerned with maintaining professionalism and professional identity. In looking at how the focused codes might relate to each other on a theoretical level, I turned to the literature to look at existing theoretical structures that might help move the analysis forwards towards theory development. In doing so, I was seeking to enrich rather than dictate the direction of focus.

With respect to learning professional roles, I was looking for models that reflected learning as an ongoing, experiential process as represented in the data. The emergent patterns were similar to Kolb's (1984) conceptualization of learning as a continuum of adaptive postures to the environment over time (p. 34). Many of the participants referenced their learning process as ongoing regardless of experience in years, and at the same time their responses reflected established practices with reference to their professional identity and maintaining professionalism. The elements of Kolb's learning cycle, namely concrete experience, reflective observation, abstract conceptualization, and active experimentation, offered a potential framework for organizing therapist's experiences and could be aligned with existing codes, for instance, *having role experiences, cultivating awareness, conceptualizing, making adjustments*, suggesting that these may be treated as focused codes.

Therapist accounts of proactive and intentional actions also led to exploration of existing theories of professional agency as a potential frame of reference in the coding process. Bandura's (1989) socio-cognitive theory contributed to the theoretical frame for data analysis as it suggested consideration of both agency and developmental processes in what he described as "a model of emergent interactive agency" (p. 1175). In this model of "reciprocal causation"

personal factors (including cognitive and affective processes), actions, and environmental events contribute to human agency (Bandura, 1989, p. 1175). Bandura (2006) posited that being an agent was to “to influence intentionally one’s functioning and life circumstances” (p.164). In terms of action, there are four properties of agency: intentionality, forethought, self-reactiveness (regulation), and self-reflectiveness (Bandura, 2006, pp. 164-165). In terms of perception, belief in self-efficacy was central to practice of agency (Bandura, 1989; 2006). Consideration of these ideas contributed to framing the analysis in terms of agentic practices.

A third model that contributed to the theoretical analysis was Schön’s (1983) analysis of developing professional competency. Schön’s concern with how professionals learned to handle problematic situations involving value conflicts that fall outside of theoretical knowledge or learned techniques is particularly relevant to the kind of challenges faced by therapists in HBFT. In his study of how professionals develop competency in their field, he identified *knowing-in-action* as an expression of practical knowledge and reflection on this knowledge as *reflecting-in-action* and *reflection-on-action* as processes of knowing (Schön, 1983). As a framework for understanding professional development that was mirrored by the emerging codes in this study, Schön’s concepts lent weight to attending to the actions associated with therapists declaration of tacit knowledge.

Each of these theoretical models contributed to the development of focused codes and contributed to forming definitions. Intentionally, I did not adopt any of them as an exclusive framework as I wanted to remain open to the data and the emerging patterns. However, exploration of existing models provided questions to ask of the data in order to move towards a more abstract understanding of patterns. Ultimately, the emerging theory suggested an experiential developmental model most closely aligned with Schön’s reflective practice,

incorporating the concepts of agency and self-efficacy.

Data saturation. According to Glaser (1978) the criteria for ending data collection is recognizing when the theoretical categories are saturated, that is when no new properties of these categories can be found and the existing properties account for the observed patterns in the data. After clarifying that the meaning of saturation is not the repetition of the same ideas by multiple parties, Charmaz (2014) presents a discussion of the difficulty in truly measuring when saturation has been achieved. In order to counter the risk of prematurely proclaiming that manner of saturation, I applied Charmaz's (2014) question to recurring patterns in the data: "Do these patterns inform theoretical categories?" (p. 213). While it seemed that no new information related to the processes under investigation was being heard in the tenth and eleventh interviews, I conducted another interview; the twelfth did not bring in new material, so I determined that the existing data was sufficient to support an interpretive analysis of how MFTs manage professional roles in home-based family therapy.

Completion. Glaser and Strauss (1967) provide the following criteria for the researcher to consider when determining when to end the study:

[the] conceptual framework forms a systemic theory, that it is a reasonably accurate statement of the matters studied, that it is couched in a form possible for others to use in studying a similar area, and that [s]he can publish with confidence. (p. 224)

In other words, Glaser and Strauss make the point that it is the researcher who first attains confidence in the credibility of her theoretical analysis as a systematic interpretation of the data.

Evaluating the Research

Glaser and Strauss (1967) challenge the use of standards associated with quantitative research to evaluate qualitative studies and propose that the criteria of evaluation must

correspond to the method of inquiry, the final product, and the process used to produce it. In keeping with the variants in their procedural approaches, Glaser (1978), Corbin and Strauss (1990), and Charmaz (2014) offer different criteria that may be used to evaluate the constructed theory and how well it fits the data; what they share in common is that in the final write-up of a grounded theory study, the reader should be able to make a judgment based on the researcher's presentation of the study. Charmaz (2014) provides a list of criteria (questions) that may be used to assess dimensions of credibility, originality, resonance, and usefulness within the following parameters: Credibility is established by making explicit the steps taken to develop theory and portraying this in a manner that the reader may assess your claims; originality reflects how well the researcher presents new insights or conceptualizations to the field of study; resonance reflects whether the theory makes sense to the participants and the reader; while usefulness reflects the potential utility of applying the analysis to the field. In the paragraphs that follow, I have outlined the primary strategies embedded in the research design that employed to enhance the credibility of the research for myself and my readers.

Ongoing observation and engagement in the field are techniques that lend support to credibility (Lincoln & Guba, 1985) enabling the researcher to answer, from an experiential perspective, the question, "Has your research achieved intimate familiarity with the setting or topic?" (Charmaz, 2014, p. 337). When I first conceived of the research topic I was a therapist who had formerly worked as a home-based family therapist; while this provided some insights to the topic, my understanding was limited to previous personal experiences in a particular setting. At the start of the research I was embedded in a work setting where I was exposed to a HBFT program culture that was relevant to my research question: My employer was an agency that had been providing HBFT services since 2009 under the state's Children's Behavioral Health

Initiative. In my position as an outpatient therapist in a sexual abuse treatment program, I sometimes provided outreach services in the home (not the same as HBFT) and often collaborated with home-based therapy teams from various agencies. In the latter part of the research I was involved in coordinating and supervising a multi-disciplinary internship that provided outreach services in the home. While this was not quite the same level of care as being provided by the participants in this research I was aware of incorporating the preliminary results in training and supervision. In this capacity, observing the interns applying these evolving ideas in practice contributed to my confidence in the proposed model.

My location and experience positions me with both an insider and outsider view that stimulates questions and curiosity. It also supports triangulation through the use of multiple data sources, including observations and documents that may contribute to the development of theoretical concepts (Creswell, 2007).

Credibility is measured by the believability of the results that can be enhanced by incorporating external checks in the research process (Lincoln & Guba, 1985). I was able to utilize peer debriefing and member checks to gain perspective on my coding processes, categories, and emerging theory. Peer debriefing was periodically used to examine my arguments for coding decisions; the role of the peer consultant, who may be a colleague or advisor, was to provide feedback on whether I had “created clear, evident connections between the data and my codes” (Charmaz, 2014, p. 160). Discussing my research decisions with a peer provided an opportunity to “explore aspects of the inquiry that might otherwise remain implicit in the inquirer’s mind” (Lincoln & Guba, 1985, p. 308).

In the theoretical sampling phase, I shared sample representations of my evolving theory verbally with participants to solicit feedback. These conversations were intended to be a

collaborative exploration of resonance in order to confirm fit and/or expose gaps in the theoretical interpretation. With this approach to member checking, participant verbal and non-verbal responses can be incorporated in the data analysis to confirm, refine, or generate new categories (Charmaz, 2014). The selection of participants for these interviews was subject to availability.

As described in the section on analysis, the research design incorporated measures to monitor researcher subjectivity through reflexive practices. In constructivist grounded theory the researcher is responsible for rendering transparent the decisions underlying each phase of the research, for example sampling procedure, coding decisions, the development of theoretical categories, and the determination of theoretical saturation (Charmaz, 2014). Self-reflection is also considered a strategy to enhance confirmability of the research (as opposed to objectivity) when used to investigate and unveil the source of our insights and how we reach our conclusions (Gasson, 2004; Lincoln & Guba, 1985). In my research these reflexive practices were recorded through the writing of memos and maintaining a reflexive journal, contributing to an audit trail of the research process. Disclosure of my positionality and experience in the area of study to my readers reveals my perspective and potential biases that may have influenced my interpretation.

The iterative process of grounded theory provides ample opportunity for the researcher to subject the findings to internal and external scrutiny (Gasson, 2004). Reflexivity and the inclusion of peer consultation and member checking as the research proceeds allows for challenges and changes in perspective as the data is constructed by the researcher and participant (Charmaz, 2011). Ultimately, the interpretation and analysis of the collective views of the participants is mine. The reader's assessment of the credibility, originality, resonance, and utility of the research will depend on how well I narrate the results.

CHAPTER 4

Presentation and Discussion of Research Findings

The primary focus of this research was to discover how MFTs manage professional roles in HBFT. Twelve MFT therapists participated in semi-structured interviews that explored their experiences providing HBFT services. Analysis of the data revealed discourses about being professional in HBFT and agentic practices that supported MFTs managing multiple professional roles. Therapists' perception of professional agency in the practice of HBFT was situated in the context of their work environment and along a developmental continuum of experience. The research themes are dynamically interactive as shown in Figure 4.1.

Research Themes

Five themes from the analysis were identified as significant to the research question.

1. *Understanding place in the system* is concerned with recognizing the systemic and institutional factors that contribute to HBFT role expectations and experiences.
2. *Having role experiences* is concerned with therapists' reflections on events that informed agentic actions in HBFT.
3. *Cultivating professional agency* encompasses the intentional practices that MFTs develop, cultivate, and utilize to manage their professional roles. *Cultivating professional agency* emerged as a central category relating to how MFTs managed professional roles in HBFT.
4. *Maintaining professional integrity* is concerned with the individual factors that contribute to the HBFT role experience.
5. *Being professional* is concerned with the discourses and processes of developing professionalism encountered by therapists in HBFT practice.

In this chapter I will introduce each of these themes and discuss their relationships and relevance to the research question: How do MFTs manage multiple professional roles in HBFT? Although co-constructed through dialogic conversations with therapists, the themes presented here reflect the researcher's analysis and interpretation of the therapists' discourses about their role experiences in HBFT and are not necessarily the view of any one therapist.

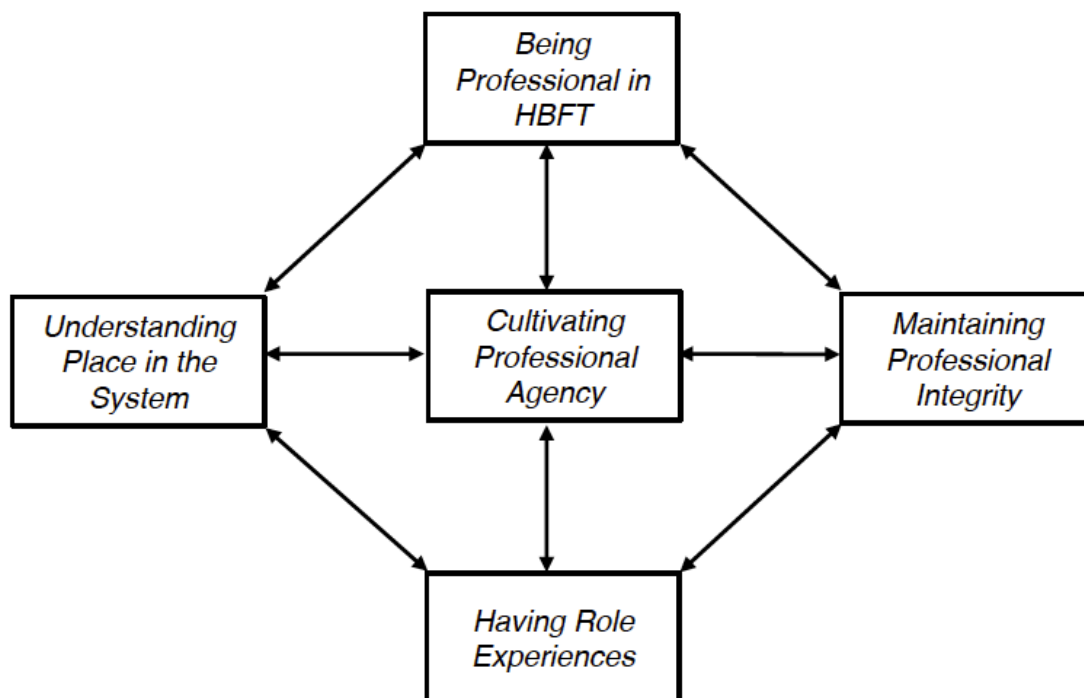


Figure 4.1 A diagram of the relationship between *cultivating professional agency* and other themes.

Discussion of the results of this research has been organized in two sections: Part I: Participants and Systemic Factors and Part II: Being Professional: Finding Professional Agency in HBFT. In Part I, I will review therapist demographics and provide an interpretive description of primary contextual factors in their professional lives as revealed in the data. This section will address the themes of *understanding place in the system* and *having role experiences*. In Part II, I

will present how professional agency is manifested through the strategies employed by MFTs working in HBFT settings to manage their professional roles. Part II addresses the themes of *cultivating agency*, *maintaining professional integrity*, and *being professional*. A discussion of the relationship of the five themes will conclude the chapter.

Part I: Participants and Systemic Factors

“We cannot forget that we are working with systems all the time!” (09-2)

In this section I will provide contextual information about the participants, their work environment and an analysis of the role challenges that contributed to their understanding of how to manage professional roles in HBFT. The themes of *understanding place in the system* and *having role experiences* will be presented and discussed. Quotations from therapists’ interviews will be identified by the participant number followed by the interview number; for example, the quote at the start of this section from (09-2) designates that it is from the second interview with the ninth participant.

Participant therapists. The participants in this research were 12 professionals with MFT training and experience in HBFT. The age range of therapists was 27 to 65. On the demographic questionnaire, seven therapists identified themselves as female and five as male; ten reported their ethnicity as Caucasian, one as Hispanic, and one as Asian.

Education and experience in MFT. All therapists had completed masters-level training in MFT: nine therapists had a Master of Arts, one therapist had a Master of Science, and two therapists had a Master of Education degree and post-masters training in MFT. Nine therapists had graduated from COAMFTE-accredited schools. Seven responded that they were members of the American Association for Marriage and Family Therapy (AAMFT); one therapist did not indicate membership status. At the time of the first interview, therapists’ post-masters experience

ranged from 6 months to 20 years (average of 5.5 years). In order to participate in the study, all therapists had identified themselves as MFT license-eligible in their state of practice: six therapists reported being licensed as MFTs, one license-eligible therapist was licensed as a mental health counselor (LMHC), and the remaining five were on the pathway towards licensure.

Experience in HBFT practice. Therapists in this research had 6 months to 15 years of experience in HBFT settings (average of 4.5 years) at the time of their first interview. Initially, therapists recruited to the study had to have worked in a HBFT setting within the last six months ($n = 9$); an additional three therapists were interviewed after an amendment to the IRB removed this constraint; five therapists interviewed reported that they were no longer working as HBFT therapists at the time of the interview.

In the demographic questionnaire, therapists were asked to identify their HBFT training experience: 6 reported having learned about HBFT practices in their degree program, 5 attended trainings at a conference workshop, 11 reported getting training at work, and 11 reported learning from supervision. In the interviews, four therapists reported supervising HBFT practice at some point in their career.

While only half of the therapists ($n = 6$) reported learning about HBFT in university on the demographic survey, it is possible that the survey question was open to interpretation as to whether it referred to theoretical or experiential learning: three therapists did not select this response but later reported having a HBFT internship as part of their degree program, while a few therapists who did outpatient internships selected this response. In all, seven of the 12 therapists indicated that they had learned HBFT practices through their internship experiences, either in an intensive home-based therapy program or when providing outreach services to families in the home or community.

Contextualizing therapists' understandings. All therapists participating in the research contextualized their role understandings, relating them to the systems they were working with. In the final analysis, these factors were ultimately absorbed into the theme of *understanding place in the system*; however, since the therapists' employment sites were the predominant system that defined their professional roles, it seems important to provide the reader with a brief description of this environment as background to the participants' experience. Based on therapists' discourses, I have included reference to the principle areas of content that were emphasized as relevant to their roles, namely the therapists' practice sites, the HBFT program mission, the families served, the service delivery, and therapists' roles and responsibilities.

Therapists' practice sites. Information about therapists' sites of HBFT practice was provided on the demographic questionnaire and in the course of the interviews; further information about these organizations was gathered from the company websites and their job offerings for home-based therapists. Twelve discrete organizations were mentioned; one therapist identified having worked for two different organizations and two therapists reported employment with the same organization, but at different locations. The practice sites for the therapists in this study were located in six states in the Eastern US: Connecticut, Massachusetts, New Hampshire, New Jersey, Ohio and North Carolina. Sites included large organizations running multiple programs nationwide, state-based organizations serving multiple communities, hospitals, and a community-based LLC. For therapists, both state regulatory factors and organizational factors contributed to defining the parameters of their job.

The program mission. The organizations employing the therapists promoted themselves as social justice oriented, culturally sensitive, strength-focused, and trauma-informed. Their program mission statements reflected dedication to promoting positive outcomes for youth,

families, and communities. Their stated objectives were to reduce risk, establish safety, and prevent placement in a higher level of care. Therapists frequently referred to program values as rationales for actions taken, particularly when *doing what it takes* to meet people where they are.

Families served. All sites offered intensive services to families with qualifying children and/or youth under the age of 21; broadly, qualifying youth were defined as having serious social, emotional, and behavioral health issues putting them at risk of placement outside the home. Some of the programs specifically targeted certain age groups or types of problematic behaviors, for instance substance abuse or sexualized behaviors. Therapists reported serving families that were frequently in crisis and having unmet needs requiring support in navigating educational, medical, legal, and/or child welfare systems. On the survey, therapists either defined their client demographic as at-risk youth; or by their socio-economic status (typically low); or by race, namely Caucasian, Hispanic, and African American. Even if mandated by third-parties, therapists were at pains to stipulate that family participation in HBFT was on a voluntary basis.

Service delivery. In this sample, therapists reported that the services they provided were intensive and time-limited. These intensive services were focused on family stabilization to prevent placement and in some cases provided reunification programs for youth leaving residential care. For families this meant that they had access to some level of service response 24/7 and therapists (teams) were expected to meet with them for a minimum number of times and/or hours a week; the reported minimum range was 1.5 hours to 6 hours. The length of service varied from program to program: for example, some programs provided an initial period of 90 days, renewable with authorization; other programs projected a duration of four to six months or six to nine months depending on treatment objectives. Overall there was an expectation that an overarching goal was to stabilize the family sufficiently to discharge them to

less- intensive services within a proscribed time frame.

The structure of service delivery teams varied according to program and reflected the heterogeneous organization of HBFT services. In some programs, therapists worked alone with the family, but had backup from other members of their supervision group who were familiar with the case and could step in if the therapist was unavailable. In other programs, therapists were teamed with a paraprofessional to provide services to the family; in most cases, but not always, the paraprofessional was from the same organization. The therapy team could be extended to include team members from other organizations, with therapists acting as the *hub* or team leaders, overseeing the paraprofessional(s) and coordinating other service providers.

Three of the therapists interviewed were employed at sites offering multi-systemic therapy (MST) or multi-dimensional family therapy (MDFT) models of treatment; a fourth therapist described having to follow a program-directed treatment protocol. These programs offered multi-level supervision to promote therapist adherence to the treatment model. Programs in other sites were not marketed as model-specific, but therapists reported being trained in specific therapy models that they were encouraged to practice.

Therapists' roles and responsibilities. Therapists in HBFT positions are professionals with multiple responsibilities in addition to providing individual and family therapy. The titles held by the participants in this study included clinical coordinator, in-home therapy clinician, in-home therapist, family intervention specialist, MDFT clinician, MST therapist, and staff clinician. However, these job titles do little to convey the multiple roles embedded in the job. Across programs there was consistency in the expectation that therapists would perform different roles as required, although the proportion of time given to specific roles varied from program to program. In addition to therapy, therapists described having the following roles: case manager,

advocate, coach, mentor, and crisis manager; related responsibilities included completing mandatory assessments, being on-call, and mandated reporting. Providing transportation was required in some positions and was discretionary in others. Other non-clinical job expectations included attending internal and external meetings as well as mandatory professional development trainings. HBFT professionals were expected to undertake designated roles to meet clients where they were at, collaborate with larger systems involved with the family, and comply with the employer mission and service contracts.

Summary. In this generalized description of the participants and their sites, I have introduced the working context that informed the responses of the therapists participating in this research. Despite the therapists working in disparate organizations and states, thematic commonalities were found. Therapists related their role expectations to organizational policies and the program model; their role definition was also subject to state regulations and funding sources. The importance of having a working knowledge of these different factors was conveyed by each of the participants as relevant to performing their job professionally. The relevance of having an eco-systemic understanding when working in HBFT is further addressed in the theme of *understanding place in the system*.

Theme 1: *Understanding place in the system*. The theme of *understanding place in the system* is concerned with therapists recognizing the systemic and institutional factors that contribute to HBFT role expectations. Therapists contextualized their experiences of role expectations through reference to intersections with the multiple systems involved in HBFT services. Understanding their professional role in relationship to other systems, as well as the roles of their collateral partners, can contribute to therapists' overall assessment of how they manage professional roles in HBFT. With respect to managing roles, one therapist recommended

that newcomers to HBFT should be aware of their relationship to the expectations of multiple systems: “You’re going to have a lot of expectations because of whatever [the] requirements are: by the laws, or by the insurance companies, or by your agency.” (01-1) The five dimensions of therapists’ understanding their place in the system discussed here are *knowing regulations*, *understanding institutional culture*, *understanding collateral systems*, *understanding family culture*, and *learning experientially*.

Knowing regulations. *Knowing regulations* is concerned with understanding the regulatory expectations for reporting and documentation. Particularly as program funding is subject to state or federal regulations, therapists are expected to comply with the governing regulations as well as follow institutional policies. Regulations dictate therapists’ roles such as having to complete periodic reports for the state; for example, as one (of many) therapists explained, “There were specific assessments that the state requires every three months.” (01-1) Knowing the source of the role expectations is important for managing roles, particularly as those associated with regulatory bodies are non-negotiable. Referring to the role of the Department of Mental Health (DMH) oversight in setting role expectations, another therapist explained the situation as part of the job:

Because the reality of the grant that we are working on with DMH says that we have to be available to the families—that they pay us 365 days per year. So the expectation is kind of like whenever they call you, whenever they have a crisis—there you are. (09-1)

Likewise, therapists may be accountable to insurance companies that have documentation requirements that have to withstand periodic auditing for compliance. An understanding of the regulations can inform therapists’ decision-making when handling role expectations.

Understanding institutional culture. *Understanding institutional culture* is concerned

with therapists knowing the program mission and policies, service delivery, and job expectations. Learning institutional culture takes time. Institutional culture has its own hierarchy and idiosyncrasies that therapists have to get to know. Speaking emphatically, one therapist stated, “I **know** the =Institution= way and I **know** what supervisors are expecting.” (06-1) Familiarity with institutional job expectations also includes understanding their role(s) in relation to the roles of other team members. Whether starting new in HBFT, or changing jobs in the system, fulfilling role expectations involves discovering which understandings are transferrable from previous positions and which are idiosyncratic to the job.

Institutional culture frequently combines the program mission with the expectations of regulatory stakeholders. Explaining the expectations of their position, one therapist illustrated the links between program mission, funding stakeholders, and delivery model:

I think if my company told you, it would be three things: It would be to provide fantastic treatment, to meet two to three times per week with my families and to set them up with different pro-social activities, [and] touch base with schools, touch base with all the key players and work the model and make sure they don’t show up in out-of-home placement.
(07-1)

Therapists may have institutional support for complying with the regulatory expectations of their funding sources, but at the same time find they have to meet additional expectations from their employers in accordance with the program. Reflecting on this, one therapist commented, “We’ve got a lot of expectations, because you have a lot just being a Medicaid state. And then =Institution= has its own.” (06-1) Notably, therapists were often at pains to differentiate between the roles driven by regulatory requirements and those associated with program delivery.

Understanding collateral systems. *Understanding collateral systems* is concerned with

therapist familiarity with the roles and institutional culture of collaborative partners. Recognizing the mission and perspectives of the collateral systems that they interact with contributes to therapists' capacity to build relationships, collaborate, and set boundaries around their own roles. Understanding that other stakeholders are working to their own institutional standards also facilitates finding common ground to work in the interests of the family. Some therapists frame this understanding as recognizing that collaborative partners are working under their own institutional constraints, with one therapist noting that it was important to be mindful that "...those institutions have a set of protocols of their own." (10-1) Other therapists commented that one of the things that made a difference in managing their collaborative roles was the capacity to understand where the collaborative partner was coming from: "It is also being able to understand how that other stakeholder views the situation." (08-1) This therapist further explained how understanding collaterals was a valuable tool that supported them in performing their own role:

So like some perspective taking skills, being able to see the situation from the probation officer's perspective so that when you go to talk with them you are able to understand what kind of responses they are going to give and how to respond to those responses, so how to explain what you are doing in the context of how the probation officers see this situation so that they can fully understand what you are doing and why you are doing it the way you are. (08-1)

Having an understanding of collateral systems and the associated roles and expectations supports therapists in establishing clarity around their own roles. Recognizing the value of this task, several organizations had provided trainings in getting to know the protocols and processes of their collateral partners and stakeholders.

Understanding family culture. *Understanding family culture* is concerned with therapists' knowledge about families and their intersections with larger systems, including the institution the therapists work for. For therapists, this constitutes understanding family cultures and how the families perceive their interactions with them as professionals. Knowing where they stand in relation to the family is critical to determining agentic practices. As a dimension of understanding their place in the system, understanding family culture involves recognizing roles and dynamics within the family and how family expectations might interact with the expectations of the other systems they are involved in. For example, when therapists are called upon to play a role in connecting the family with other systems, they can take part in providing insight into the family perspective to help bridge the relationship, and at the same time, help families understand the perspectives of the collateral systems. For family therapists interviewed, having an understanding of family culture and family systems was embedded in their identity as MFTs; that dimension will be discussed further under the theme of *maintaining professional identity* in Part II.

Learning experientially. *Learning experientially* on the job is the principle modality for understanding roles, expectations, and other dimensions of working in HBFT. For many therapists having prior internship experience in HBFT prepared them for doing home-based work. One therapist described their learning trajectory from internship to work:

But I think as far as doing the in-home work and preparing for that, like my internship was doing in-home. My first intern[ship] or practicum was in-home therapy, then I went to do outpatient. I went back to in-home therapy in.... So I think that it's just like on-the-job learning. Yeah. A lot of on the job learning. (02-1)

Therapists who interned in a HBFT setting reported that this experience contributed to their

understanding of professional roles by providing a learning environment where they could observe how different people managed these situations first-hand and try things out while under intensive supervision. Therapists who came into HBFT jobs post-masters having had no prior in-home experience were the most vocal about the challenges of adjusting to being professional in the home environment and getting acculturated to performing different professional roles. As a new hire, it was difficult for them to reveal these challenges due to the perceived expectation of being competent for the position.

Even with some prior experience, learning how to practice in HBFT can be intense. Gesturing a sharp incline, one therapist commented, “I think the learning curve was like...you know, like very steep! Very, very steep.” (02-1) Standards of institutional orientation are variable with some therapists reporting that their initial orientation was largely administrative and that they were on their own as far as figuring out where they fit in the system. For most, getting to know role(s) and institutional expectations was a matter of acclimation over time. One therapist explained their own experience of transitioning from working in outpatient care to HBFT:

It was a big adjustment to get used to being out on one’s own, but as I had more cases and more connections to systems, I got used to it. It took me about six months to get comfortable. (01-2)

In addition to learning their place in the system, many therapists may have to learn to work within the framework of specific models. For those working in organizations that provide model-based therapies, the added requirement of learning to adhere to the model contributes to the learning curve.

Having the opportunity to observe peers and consult with supervisors helps therapists get to know the institutional culture and learn ways to manage role expectations. Reflecting on their

orientation to the job, therapists indicated that the work-based trainings were particularly helpful; one remarked that, “In the beginning that was really beneficial, because it is like learning a whole another language at =Institution=.” (06-1) Besides trainings, observing their peers, and consulting with supervisors, therapists learn on the job by doing and having role experiences that help them understand their role and place in the system.

Concluding *understanding place in the system*. Therapists’ roles in HBFT are determined by both state regulations and organizational policies; institutional expectations are also informed by the program model of HBFT services. Understanding the regulations and policies that define roles and expectations is necessary knowledge for therapists working in HBFT. Understanding the roles, expectations, and perspectives of the families and collaterals they work with is relevant for therapists to establish boundaries around their own roles. Experiential learning and training on the job are direct pathways for therapists to gain an understanding of their place in the system.

Theme 2: *Having role experiences*. The theme of *having role experiences* is concerned with therapists’ reflections on situations that informed agentic actions. In the course of explaining their multiple roles and responsibilities in HBFT, therapists reflected on how they handled specific role experiences. Analysis of therapists’ role experiences contributed to defining the agentic practices that therapists engaged in to manage their professional roles. In this exercise of *reflection-on-action* (Schön, 1983), therapists’ narratives revealed common experiences of handling role dissonance in HBFT work. These role experiences were frequently identified as challenging or frustrating situations, however accounts of managing them effectively aligned them with specific proactive actions. While existing research has focused on how failure to manage these kinds of dilemmas contributes to a diminished sense of self-efficacy and loss of

control, I have focused on how therapists' reframed these experiences in narratives of professional agency; these will be addressed in the theme *cultivating professional agency*. For the purpose of analysis, therapists' role experiences were categorized as *experiencing role dissonance* and *experiencing role congruity*.

Experiencing role dissonance. *Experiencing role dissonance* is concerned with therapists' discomfort or sense of uneasiness when performing their role(s) or meeting role expectations. Therapists often presented these experiences as role dilemmas, namely, *feeling role conflict*, *juggling different perspectives*, and *blurring of boundaries*.

Feeling role conflict. *Feeling role conflict* reflects situations where the therapist experiences dissonance between two roles in their job or a job role and personal professional identity. Role conflicts come up when responsibilities of one role interfere with those of another role, most particularly the therapeutic role. For instance, some therapists reported feeling uncomfortable when they were required to take on case management and documentation responsibilities that interrupted therapeutic continuity. Expression of frustration tended to run high in situations where the need for advocacy and collateral contacts felt disproportionate to time spent in therapy, to the extent that some therapists reported that they were so busy performing non-therapeutic roles that they felt their knowledge and skill as an MFT was wasted in the job. The therapists' dual role as a mandated reporter was also seen as problematic as it posed the risk of interrupting trust in the therapeutic relationship.

Role conflicts are also experienced in situations where there is an imbalance in power, for instance when a therapist is a team leader in the position of overseeing an older or more experienced paraprofessional, or when they are trying to work collaboratively with another therapist while in a dual role as their supervisor. Role conflicts also occur in situations where

therapists need to maintain working relationships with conflicting parties without losing trust on either side, for example being an advocate for families while maintaining collegial relationships with the representatives from child welfare or juvenile justice that their program relies on for referrals.

Feeling role conflict also occurs when a role is perceived to be outside the boundaries of the therapists' professional identity. Therapists referred to "feeling like a social worker" (05-1) or "having to cross the line to advocacy" (04-1). A number of therapists described degrees of identity confusion when trying to integrate being a HBFT with their professional identity. In some cases, as below, the different identities may not fully integrate:

Incidentally, that was a big split for me: I felt like for a while in the beginning I could apply my MFT-ness to being a MST therapist, but once I hit a certain point: I felt like I wasn't being as expressive and as creative as I would like to be in treatment which, I mean, then killed my overall sense of enjoyment in what I was doing. (07-1)

For some therapists, this disjunction between role and identity ultimately contributed to the decision to seek alternative employment while other therapists reported experiencing an integration of their role and identity over time.

Juggling different perspectives. *Juggling different perspectives* occurs when a therapist has to balance the expectations and obligations of their role(s) with having a different perspective regarding a situation from the family, the supervisor or employer, or another provider or stakeholder. For instance, therapists working from the system of care perspective of family-driven practice, or the tenet of meeting the client where they are at, have to find ways to balance their professional opinions with family defined objectives. Therapists are not immune to having conflict with the family, particularly when services are voluntary but mandated; for example,

therapists reported feeling dissonance when they believed that the family was not acting in the child's best interests.

Likewise, having to navigate relationships with other systems, like the juvenile justice system, that had a different purpose and attitude towards youth behaviors from mental health providers can contribute to role strain. One therapist explained their dilemma:

So, there was always interdisciplinary conflict between the probation, DCF and the clinicians. The probation officer wanted to violate him and send him back to out-of-home treatment or detention, where I was trying to explain to the judge and the probation officer that relapse is part of progress and given his age and the theories we operate under he needs to be around his family and given another opportunity. (10-1)

When different perspectives do not align, and stakeholders were not on the same page, the resultant tension can interfere with the therapeutic process.

A third area of conflicting perspective has to do with a misalignment of perspectives with employers and supervisors regarding therapeutic or administrative expectations. Therapists reported feeling constrained by employer values or protocols, particularly when they were told that they had to do (or not do) a particular thing that they felt was therapeutically indicated. In one example, a therapist was told that they could not provide parents with psychoeducation on trauma because the youth did not meet the cut-off on the trauma assessment despite there being a chronic history of abuse; in another example, the therapist had been reprimanded for providing psychoeducation on safe sex to a youth because it was not in line with the religious mission of the organization.

In the administrative sphere, therapists reported dissonance when the expectation that they meet with clients in order to meet productivity requirements imposed a hardship on a family

already overextended with service providers or was seen to be therapeutically unnecessary. In these types of situations, therapists experience a dissonance between their ethical sense of working in the clients' best interests and supervisory directives. One therapist described how they felt conflicted by the competing demands:

There was an underlying ulterior theme that, "Get your hours in. Get your six hours in for your family." And if you don't, there is a follow-up the next week in supervision and in group supervision to say, "Why didn't you meet your six hours?" And so, we were almost being forced to sit there with families and I know that a few therapists of mine and I probably did it a few times too, where I didn't need to [do therapy], where I was just talking about nothing with them and we were just talking....So, I almost thought it was borderline unethical that—say for example a family met their goals with 4 hours instead of 6—we were still required to go to the other two. (07-1)

As institutional requirements are based in regulatory and program protocols, therapists have to contend with situations that are constraining and non-negotiable.

Therapists may also find themselves caught in a double-bind with mixed messages from supervisors about work expectations; for instance, it is common practice for organizations to promote self-care and at same time expect therapists to prioritize client needs over everything else. One therapist described a common dilemma of being pressured to organize their work schedule around client needs after being told that the job offered flexibility in setting personal work hours:

There was one message like I said of flexibility and part-time and all of this and there was this other [message] that's like, "You have to be available all the time." (11-1)

In these situations setting work-life boundaries can put therapists at odds with their employers

resulting in role strain.

Sometimes supervisor (or employer) directives put therapists in conflict with key players (including the family); other times the alignment of supervisors and key players put therapists in conflict with family members. This challenge of balancing different allegiances was a stressor for many therapists:

It was just.... things like that: to be able to advocate for your families, still listen to your supervisor, and try to find that balance of what you should do for your families, [while] still having a relationship with your supervisor and balancing all that. (06-1)

In summary, therapists experienced role dissonance when having to manage different perspectives while maintaining relationships with all involved parties. One therapist summed up the challenge as: “There are too many cooks without defining who gets the most weigh-in.” (10-1) Juggling different perspectives is a balancing act that has to be performed on an ongoing basis (see *adaptive practices* and *proactive practices* in Part II).

Blurring of boundaries. *Blurring of boundaries* is concerned with situations where there is uncertainty over what constitutes a boundary crossing in HBFT. In the context of intensive services, the line between friendly professional and friend presents particular challenges to therapists. Meeting clients where they are often places therapists in situations that are seen as non-traditional or informal. Therapists observed that boundaries are often blurrier in HBFT than in outpatient settings. Role dissonance often occurs in situations where therapists have to decide where to draw (or reestablish) the line between being professional and being social. Boundary blurring can result not only in therapists “losing their boundaries” (02-1), but also can contribute to clients misunderstanding boundary expectations. When there is a lack of role clarity, families may develop unintended expectations of their therapist and therapists can be drawn into

unintended social roles.

In HBFT, therapists often engage in activities with clients in the home and community, for instance, assisting with cleaning up, sharing food, or attending social events, in order to meet certain treatment objectives. This was frequently referred to as “meeting them where they’re at” (12-1) or as doing “whatever it takes” (08-1). Commenting on this, one therapist explained:

In the manual they have, it specifically states that in order to do whatever it takes for the family, you might be doing some of those more questionable boundary things. For example, in order to help understand a youth’s social skills in a social environment, sometimes the therapist might attend football games to be able to see how the youth interacts with his peers in a social setting among others and stuff like that. (08-1)

In these situations, where therapists is seen as a guest, visitor, friend, or companion, the relational boundaries can get blurry. Sometimes therapists reported finding themselves in situations with clients where the participation in social activities or services became an expectation that defined the interactions rather than the original therapeutic intention.

It is like, “Oh, if it is going to build rapport, you know, go drive through Dunkin Donuts and buy them a coffee.” And then at some point the clients start to expect that. (06-1)

In the absence of boundary setting, there are opportunities for family members (or therapists) to misinterpret the friendliness and informality as an invitation to develop a more personal relationship; for example, therapists were invited to share Facebook pages, become godparents, attend family events, stay over for dinner, or, in an extreme situation, form a romantic relationship.

Boundary blurring also occurs in the domain of managing work-life balance. Therapists reported the challenge of balancing responsiveness to clients—namely living up to the value that

they did “whatever it takes” (08-1)—and establishing boundaries between work and personal time. This is manifest in implicit expectations that therapists will make themselves available 24/7 and that they work on a flexible schedule. Therapists reported that work often impinged on their evenings and weekends and that the expectation of providing extended hours of availability by cell phone often resulted in receiving calls when at home or out with family.

In summary, three dimensions of role dissonance are *feeling role conflict*, *juggling different perspectives*, and *blurring of boundaries*. These dimensions account for both discrete events and ongoing challenges that can occur in HBFT work environments. Reflecting on role experiences reveals personal interpretations of how therapists have managed their roles and how they might manage them differently. Examples of role dissonance are counterbalanced by therapists’ proactive approaches to managing situations of role dissonance, drawing on life skills, professional training, and on-the-job learning, often resulting in therapists’ accounts of self-efficacy in managing professional roles. Experiencing self-efficacy will be discussed further as a dimension of theme four (*maintaining professional integrity*) in Part II.

Experiencing role congruity. *Experiencing role congruity* is associated with therapists understanding their roles and feeling competent in doing them. Therapists’ experiences of role congruity are reflected in narratives of positive experience where they felt comfortable in the role(s) they were performing. Therapists sometimes felt congruity in one role but not another. Therapists who were new to HBFT, with limited prior experience working with families in the home environment, reported feeling more congruent in the role of therapist than in less familiar roles; experience in HBFT provided opportunities to work toward other roles into their practice. With respect to managing different roles, one experienced therapist stated that they had reached the point where “...I don’t find it so difficult to switch hats, because it’s all one hat to me in

some ways.” (02-1) Another therapist echoed this stating, “No.... Not switching between roles. I kind of see it all as incorporated into one: I am an onion with many layers.” (05-1) The same therapist went on to suggest that feeling role congruity was more about the orientation or attitude taken:

I have always been a flexible person, so you kind of need that flexibility to just roll with things that are going on and so I have never felt a conflict in between any of the roles I have at this point. (05-1)

Whether therapists attributed experiencing role congruity on the basis of experience or attitudinal states, cumulative experiences of role congruity were associated with therapists’ reflections on self-efficacy in their work in HBFT.

Reflection on *Understanding Place in the System and Having Role Experiences*

In this first section I have introduced the participants and the context of their employment in order to provide an overall picture of the conditions that informed the therapists’ narratives analyzed in this study. *Understanding place in the system* provides a pragmatic map of the landscape that helps therapists know their own role and how it intersects with other stakeholders and involved players. It is both a practice, with respect to the effort given to understanding relationships with other systems, and a knowledge-base that can be drawn upon to inform action. This knowledge-base is derived from observation and learned experience on the job.

Understanding place in the system both informs and is informed by therapists’ role experiences. Therapists’ role experiences reflect a variety of intersections between therapists and players from multiple systems. In every case, their narratives are situated in the context of reconciling the external role expectations that come from different systems—the state regulatory system, the institutional system, collaborative systems, and family systems—with their personal

professional values and identity. Therapists' accounts of how they managed their professional roles effectively when experiencing role dissonance introduced discourses of what it means to be professional in HBFT. These will be addressed in the theme *being professional* in Part II.

Part II: Being Professional: Finding Professional Agency in HBFT

In Part I, the importance of therapists understanding systemic role expectations—for themselves and others—has been discussed as relevant to knowing how therapists manage professional roles. As has been previously mentioned, discussion of therapists' experiences with managing roles introduced the concept of being professional as a recurring theme. Reflecting on changing roles, one therapist stated, “But I think it’s about maintaining professionalism, you know: Do your best to maintain that.” (02-1) In this section, I will illustrate the actions taken by therapists to manage professional roles and maintain professionalism through the themes of *cultivating professional agency* and *maintaining professional integrity*. I will then conclude with discussion of the final theme *being professional* and a summary of the relationship between the themes.

Theme 3: *Cultivating professional agency*. The theme *cultivating professional agency* is concerned with the intentional practices that therapists develop, cultivate and utilize to manage their professional roles in HBFT. The six areas of practice are:

1. ***Reflective practices*** are concerned with therapists' processes of self-monitoring and evaluating their actions through reflection on past, present, and future experiences.
2. ***Communicative practices*** are concerned with communication between therapists, clinical team members, supervisors, stakeholders, and other collateral partners involved in a family's care.
3. ***Proactive practices*** are concerned with intentional actions taken by therapists to manage

roles and role expectations through preparing, planning, and organizing in advance.

4. ***Adaptive practices*** are concerned with actions taken by therapists to be more effective in meeting the client by doing whatever it takes in order to meet them where they are.
5. ***Relational practices*** are concerned with the steps taken to engage and maintain rapport while cultivating collaborative partnerships with the people involved in HBFT.
6. ***Sustaining practices*** are concerned with actions taken by therapists to care for themselves professionally and personally in order to meet the challenges of their positions.

The relationship between these practices is dynamic and recursive. *Reflective practices* are the primary practices informing the other practices through *communicative practices*. Combined, the six practices form a coalition of practices that promote the experience of professional agency in the workplace.

Reflective practices. *Reflective practices* are concerned with therapists witnessing, processing, and evaluating their actions through reflection on current and past experiences. Through reflective practice, therapists draw on their lived experience, knowledge, and skills to understand situations—both challenging and successful—in order to respond more purposefully in the moment or proactively in the future. Three elements of reflective practice are discussed here: *cultivating awareness*, *assessing experiences*, and *formulating action*. Sample therapist statements supporting the reflective practices of *cultivating awareness*, *assessing experiences*, and *formulating action* are presented in Table 4.1. This format of providing a table of exemplars will be utilized for each of the agentic practices.

Cultivating awareness. *Cultivating awareness* is the practice of being aware of actions and experiences while remaining attentive to social cues and environmental conditions. Being

aware means listening to internal feelings of dissonance that signal that something requires attention. In this reflective practice, therapists are mindful of their sensory, affective and cognitive responses to experience. Cultivating awareness of each of these dimensions presents an opportunity for therapists to proceed with reflection on the larger picture, connecting it to their knowledge and understanding of best practices.

Assessing experience. *Assessing experience* is an internal dialogue questioning what is happening or has happened in a given situation. Asking questions of themselves invites a deeper level of thinking about process, roles, and boundaries and with awareness serves as an internalized supervisor. Having a systemic perspective, therapy training, or ethical stance are common perspectives that inform therapists' assessments; considering factors of family culture, strengths, trauma, or stressors also provides a lens that informs how therapists reflect on their work with the family. Through assessing the situation, therapists monitor their own processes and make use of this awareness to act purposefully instead of reactively. Progressing from awareness to assessment of the larger picture is the basis for formulating a plan of action.

Formulating action. *Formulating action* is concerned with the direction taken in response to the situation on the basis of awareness of process, experiential understandings, and knowledge. In formulating action, therapists access professional stances and understanding of family culture and other systems. The process of formulating action is internalized with experience, described by therapists as a felt-sense of knowing (what to do), thinking on your toes, or figuring it out as you go. Serving as a regulatory process for therapists' behaviors, formulating action constitutes the motion to engage in other agentic practices.

Concluding reflective practices. *Reflective practices* are positioned at the center of therapists' agentic practices. Moving from cultivating awareness to questioning processes, from

Table 4.1

Exemplars of Three Elements of Reflective Practices

Reflective practices	Exemplars
Cultivating awareness	<p>It's like you start having this feeling that something is just not quite right, something is not adding up. (06-1)</p> <p>It comes back to your awareness and understanding of the flow of the system. (10-1)</p> <p>So, I try to be mindful and think about all those things.... (04-1)</p> <p>You have to become aware. If you are not aware of what's going on it's going to be easy to be affected by it. You kind of have to have that moment of clarity when you [think]... (03-1)</p>
Assessing experiences	<p>(continued from above) "Okay. This is what is going on. This is what I am doing. This is how I am affecting it or being affected by it." (03-1)</p> <p>So that's the only thing I wanted to talk about, because when we are home, sometimes we are scared or sometimes we are too comfortable. And so we need to delineate: "Okay. What is this family doing? What is the system telling me? And why am I feeling this way?".... What am I talking about? What am I doing? What is my role? (09-1)</p> <p>And a lot of it is taking that extra second to think about, "Is this appropriate for me to do or do I not feel comfortable?" And if you don't feel comfortable, try to figure out, "Well, what is going on with that? Why don't you personally feel comfortable?" And if it's a fairly valid reason, then you probably shouldn't be doing it, you know. (05-1)</p>
Formulating action	<p>Realizing over time how I approached a case—how some ways actually might have been more effective—so I might kind of adjust how I went in and maybe meet with parents more. (01-1)</p> <p>And so not to have all these big grand expectations, but realizing these people have lived a long life. You just coming in here is not automatically going to change it, you know.... So just try not to be so gung-ho. (05-1)</p> <p>It is like an osmosis kind of situation, just like a cell regulatory kind of thing where I need to adjust, but at the same time I need to differentiate and integrate. So your ability to retain yourself while making adjustment is the balance that is required....(10-1)</p> <p>We know things, but cannot express it. I know that I read it somewhere, I know I needed to do it, but I need to go back to refresh. The intuition has been educated. (09-2)</p>

assessing experiences to formulating action, therapists process their experience to arrive at a proactive response. Through reflective practices, therapists tap into their implicit and conceptual knowledge. As agentic practices, reflective practices are intentional, proactive, and cultivated through experience and practice. There are two temporal dimensions of reflective practice, namely retrospective review and reflection in the moment; these dimensions align with Schön's (1983) *reflection-on-action* and *reflection-in-action*, respectively.

Communicative practices. As an interpersonal exchange or transmission of information informed by reflective practices, *communicative practices* constitute the voice empowering other agentic practices. Often referred to as “having the conversation”, the communicative practices of interest to this study address specific topics that are essential to managing roles and expectations in HBFT. Informed by the HBFT values of promoting collaborative engagement and privileging family voice, these conversations are intentional and are handled with flexibility and nuanced sensitivity to the needs of the situation. Arising from reflection, they are anticipated with forethought and initiated in the moment as required. Specific conversations relevant to this research are *explanatory*, *transactional*, and *dialogic*; exemplars of each type of conversation are shown in Table 4.2. *Communicative practices* include:

- *Explanatory conversations* that are intended to clarify roles, communicate expectations, or set boundaries; these are directed by therapists (or supervisors) at the start of the relationship and initiated as needed for the duration of the relationship.
- *Transactional conversations* that are intended to provide and/or receive relevant information in order to stay on the same page; information sharing is initiated at the start of services or collaborative partnership, and can be a singular event, or consist of brief and regular updates with partners and stakeholders according to program protocols. Being

mindful of confidentiality, conversations with collaborative partners and stakeholders concerning clients are constrained by purpose, program model and role expectations.

- *Dialogic conversations* are collaborative discussions that are intended to establish rapport, define outcomes and identify shared objectives; therapists are influential in facilitating privileging client voice in these conversations on an ongoing basis.

Table 4.2

Exemplars of Three Types of Communicative Practices

Communicative practices	Exemplars
Explanatory	<p>...from my experience, if I don't just come into a family and I just say, "Listen. These are the reason why I am here. This is what we need to accomplish. This is my role," and clearly define everything, right out on the table. (07-1)</p> <p>So, things like that have to be addressed...and openly talk about it and how to get out of that [situation]. And teach them even better to know next time, you know: What can you do with a clinician and what can you not do? And what is expected of both. (09-1)</p> <p>So it takes a little explanation on our part to help them understand that. (08-1)</p>
Transactional	<p>So, I just sort of regularly check-in with people. I think it helped everybody to stay on the same page.(01-1)</p> <p>Really our duty is to report to them is, "Is the family progressing or are they not?" We don't need to give them all the specific details on the things we are working on. (08-1)</p> <p>So just everybody being able to communicate effectively and openly and being able to say, "I think that we should have a meeting about this," I think has been the best. (06-1)</p>
Dialogic	<p>We have a lot of ways we can engage with you, but ultimately at the end of the day we expect to sit down and be talking with you and the child, or whomever is directly involved in their care. (03-1)</p> <p>And having that conversation with the family to know "What is their focus?" (02-1)</p> <p>It was better with communication. When I did have a conversation about changing what they were doing, they accepted it. It was better being more collaborative. (11-2)</p>

Concluding communicative practices. *Explanatory, transactional, and dialogic* conversations are entered into with the intention of furthering the other agentic practices on an interpersonal level. Being communicative in different roles is considered a desirable professional trait. The conversational type may shift with role changes and the underlying goal(s) of interaction, however, timeliness and consistency in communication are critical to all communicative practices. When asked to comment on the emerging themes, one therapist remarked, “There was a lot of communicating with everybody and getting on the same page.” (01-2) Confirming this, another therapist added that in HBFT it was the professional’s role to be “making sure communication was always on.” (09-1)

Adaptive practices. *Adaptive practices* are steps taken to moderate therapists’ actions in order to work effectively in line with the HBFT value of doing what it takes to meet clients where they are. Adaptive practices reflect therapists’ working with flexibility and readiness to change their approach as needed. Three adaptive practices are *adjusting, accommodating, and going above and beyond*. Exemplars of the three adaptive practices can be found in Table 4.3.

Adjusting. *Adjusting* occurs when therapists modify their role based on assessment of the situation. In making adjustments there may be a change in roles, or a change in how the role is performed. Frequently referred to as “being flexible”, therapists maneuver their roles in order to best respond to the needs of the moment or location. Common situational shifts are from the therapist role to crisis management, mandated reporting, or case management; role shifts based on location include advocacy in schools and at court, or providing transportation. Role shifts may be anticipated, as when going to court or conducting mandatory periodic assessments; or they may be navigated in response to a presenting situation, as when helping a client undertake a task.

Situationally, in accordance with organizational culture, therapists may adjust by exchanging roles with a team member on the basis of availability, ability, or experience.

Another way that therapists adjust roles is through calibrating their interactions with others, acting with sensitivity to people's roles, the setting, and situational needs. Therapists make adjustments taking into consideration family culture and community. When applied to sharing information with outside parties through *communicative practices*, adjustments are made taking into account audience, purpose, and timing. Calibrating interactions in a timely way supports engaging and maintaining rapport in *relational practices*, and supports the *sustaining practices* of setting boundaries.

Accommodating. *Accommodating* is the practice of responding to external demands on scheduling, duration and frequency of sessions, and accessibility to make it work. In the HBFT model of care, therapists are expected to be flexible in accommodating their schedule to meet the clients and other members of the team. Making accommodations in scheduling time or location may occur in tandem with role adjustments: for example, arranging to meet on short notice or extending sessions for crisis management, stepping forward to advocate in schools or court, or switching to case management or coaching when in the community.

Going above and beyond. In order to accommodate or adjust, being flexible often requires putting in extra time, effort, and persistence to manage different roles. In order to meet the specific objectives of different roles therapists may choose to extend the session, or add an extra session. In order to manage the collaborative dimension of HBFT therapists allocate time to meet with other involved providers as well as work intensively with families. Working with mandated or reluctant clients requires extra effort to build relationships and establish trust. *Going above and beyond* necessitates establishing a balance between effort and self-care.

Table 4.3

Exemplars of Three Adaptive Practices for Managing Multiple Roles

Adaptive practices	Exemplars
Adjusting	<p>And then, you know, being able to switch that hat quickly when it needs to be switched. (02-1)</p> <p>If need be, I'll take a really active role so that [if] the parent is either unable or unwilling it still gets done. Yeah. So, I probably cross the line to advocacy at points.... (04-1)</p> <p>So if it comes down to: there is a serious need for this person to be in this location for that, but there is a barrier to getting her there, then I would propose to them at that point that, "It is an option for me to come and take you to this appointment. (08-1).</p> <p>But sometimes the paraprofessional may have an expertise, like knowing the court system and a probation officer and the clinician may just take a step down and allow the paraprofessional to do that piece of advocacy and she or he is there for some more support for the family. (09-1)</p> <p>I think it needed to be handled with some savviness in the sense of knowing your audience, who you were talking to, and when to bring it up. (08-1)</p> <p>Maybe I need to change my approach.... (12-1)</p>
Accommodating	<p>You need to be attentive to time with families: you may need to be flexible to be earlier or later depending on what the family needs. (09-2)</p> <p>... I flew over to this family's house and showed up after an escalation incident happened, like immediately after. (07-1)</p> <p>I loved the ability to be more flexible. I loved the ability to: if I needed to stay with the family for 30 minutes I could do that; if I needed to stay with them for three hours.... (01-1)</p>
Going above and beyond	<p>I probably worked a little bit longer and harder.... I might also try to add on an extra visit that week so that I could have more of a therapy session. (01-1)</p> <p>So I kind of look at what's going on for the family and, and do my own assessment and then make a decision about what they're capable of and then I might, depending upon what it is, I might do extra. (02-1)</p> <p>Because no matter what I said she was not hearing me and I went above above-and-beyond with it: I got them everything, [I] was on top of everything for them, was talking to them, updating them regularly to the point of when I was just asking her to call me when incidents happen, "Call me, call me, call me," but she would never do that. (07-1)</p> <p>We give them our all. (09-2)</p>

Concluding adaptive practices. *Adaptive practices* are steps taken by therapists to accommodate or adjust in response to situational demands. Informed by reflexive practices, the practices of adjusting and accommodating are associated with being flexible and ready to navigate across systems. There was consensus amongst therapists that being flexible and ready to “roll with the punches” was a desirable attribute in HBFT (see *maintaining professional integrity*). In the words of an experienced therapist, “You have to be flexible and always negotiating with the family and system as well.” (09-2) Preparedness to engage in adaptive practices is intentionally supported by proactive practices. At the same time, the expectation that therapists make the extra effort to keep up with multiple role responsibilities demands that therapists are agentic in engaging in *sustaining practices*.

Proactive practices. *Proactive practices* are concerned with intentional actions taken by therapists to manage roles and role expectations through preparing, planning, and organizing in advance. Proactive practices are informed by skills and expertise derived from life experience in tandem with support from supervisors and colleagues. Two proactive practices are *planning* and *organizing*. Specific examples of proactive practices are provided in Table 4.4.

Planning. *Planning* is being prepared in advance for the role(s) that therapists are expected to fill. In practice this means having multiple courses of action planned in anticipation of different roles to meet the needs of a range of situations. Due to the high frequency of crisis situations in HBFT, therapists need to be mindful of potential safety concerns and prepare for different contingencies. Planning includes anticipating what to say in conversations when setting boundaries and managing accessibility. As a preemptive strategy, planning proactive communication to clarify roles and expectations helps therapists manage different roles.

Planning for different roles also includes researching interventions and assembling a range of resources to perform the associated tasks. Having resources on hand to use in session, whether they are for activities or interventions, information about community services, or extra copies of authorization forms to release information in the event that a new person joins the session, constitute a therapist's tool kit. As developing the toolkit is a planning task in itself, a common strategy for gathering useful tools calls for being on the lookout for anything that is relevant to support specific roles on an ongoing basis.

Organizing. *Organizing* is concerned with time management and administrative actions that therapists use to manage their roles and prioritize activities. Effective organization supports therapists meeting the professional objectives of being punctual and consistent. HBFT therapists have to effectively manage a schedule that includes sessions with families, team meetings, collateral contact, supervision, consultations, in addition to making time for documentation, travel and trainings. In order to meet regulatory requirements it is important to be organized around documentation, reporting timelines, and case management tasks. Effective time management creates space to complete the tasks that supported planning activities, managing the organizational demand of meeting productivity, as well as making time for self-care.

Concluding proactive practices. The proactive practices of planning and organization are intentional steps taken by therapists to manage roles and role expectations effectively and efficiently. Engaging in proactive practices, particularly developing good time management skills, serves the dual function of meeting employer expectations and reducing job stress through preparedness. Proactive practices are performed in advance of anticipated need and are reviewed and revised through reflective practices. Proactive practices provide a framework for therapists to engage in each of the other practices, including *adaptive practices*.

Table 4.4

Exemplars of the Proactive Practices of Planning and Organizing

Proactive practices	Exemplars
Planning	<p>I usually from almost when I get there I pretty much have a plan. (04-1)</p> <p>But generally, if you have a situation that has got the potential to go there you're going to have plans in place before it gets there. (12-1)</p> <p>... always being two or three steps ahead as far as knowing what kind of response. (10-1)</p> <p>So, I think as an in-home family therapist you need to have your bag and you have to have many things in there, because you go, and you don't necessarily know what we going to be faced [with] today....I think we are better equipped if we have the tools in the bag. (09-1)</p> <p>It's just being conscious: just really be conscious of everything that's around you and look into finding any resources that you can. (05-1)</p>
Organizing	<p>Being organized is a huge piece. (02-2)</p> <p>...they have to do all that while still being = INSTITUTION = compliant and Medicaid compliant, so helping them, you know, manage their schedules and finding time to balance all those different responsibilities. (06-1)</p> <p>I've created some tracking tools to help me keep track of what I am doing more....that I can use to track all the different—whether I am making phone call, connecting with collaterals, doing paperwork, travel time—all these different things you're supposed to keep as far as billing goes. I have one: it's to track things I need to do, like if I have a comprehensive assessment coming up or I need to make sure to follow up with the psychiatrist.... (03-1)</p> <p>So, I think even maybe that's another area of where I probably would have been able to be more—spend more time in—is doing more research or doing, gathering, preparing for sessions more thoroughly and just researching in terms of finding more effective interventions. (01-1)</p>

Relational practices. *Relational practices* are concerned with the handling of interpersonal relationships in HBFT. Relational practices are value-driven and inclusive. While engaging the family is at the center of relational practice in HBFT, the principle of building relationships also extends to team members and other collaborative partners. Relational practices

include *building relationships* and *working collaboratively*. Table 4.5 provides exemplars of *relational practices*.

Building relationships. *Building relationships* is foundational to relational practices as an ongoing process of engaging and maintaining rapport with families and the other parties involved in HBFT. Sound therapeutic relationships are necessary to sustain effective collaborative partnerships. As a first step towards establishing a working relationship, skilled therapists reach out to engage people's interest (or motivation) in order to get buy-in and commitment to participate in HBFT services. Likewise, establishing rapport with collaterals and referral agencies is just as important as building relationships with families, not only to maintain incoming referrals, but to readily access supportive services for families when necessary. With all parties, maintaining a respectful attitude and establishing trustworthiness over time supports the development of collaborative partnerships.

As a practice, building relationships with families and collaborative partners is prioritized from the first encounter. Building relationships requires time and effort: In many respects, it is an on-going process of engagement and re-engagement through providing repeated experiences of trustworthiness and demonstration of reliability. This calls for being curious but respectful and taking the time to get to know people's perspectives. With families, this means being mindful of family values and making an effort to join with the family system, building rapport through appreciation of their interests. In HBFT, therapists have opportunities to engage in relational activities with families that are not typically associated with (outpatient) therapy in order to build rapport. With multi-stressed families, trustworthiness may not take hold until after the therapist has provided support through a crisis.

Working collaboratively. *Working collaboratively* means engaging with the family and

other systems to work towards common goals. As a HBFT job expectation, being collaborative is a guiding value that permeates every level of practice. Within organizations, collaboration between team members and supervisors is considered a key element of service delivery. Likewise, therapists are expected to collaborate with external parties involved with the family. Therapists work collaboratively with families and include extended family and social supports as needed. Working collaboratively in HBFT is goal-driven and therapists are responsible for facilitating constructive communication between parties from the outset of services. Two principles that guide therapist roles in collaborative work in HBFT are *privileging family voice* and *finding common ground*.

Privileging family voice is defined as listening for the family perspective and bringing it to the fore in collaborative practice. Therapists privilege the family voice by engaging them in identifying goals and by promoting their taking an active role in moving towards discharge. By working side-by-side with family members to solve problems and obtain resources, therapists promote client agency and responsibility. When collaborating with other professionals, for instance in schools or in courts, therapists may step forward to amplify the family voice through articulating or advocating for the family's perspective until the family is ready to assume the role for themselves.

Finding common ground as a principle and practice is concerned with aligning the family perspective with the perspectives and mandates of other providers or stakeholders. Finding common ground helps prevent the various involved parties from working at cross purposes or replicating services and is relevant to maintaining role clarity. Effective collaboration relies on good communication and information sharing to keep the family and collateral parties on the same page in terms of goals and objectives. Collaborative therapists assume a bridging role

Table 4.5

Exemplars of the Relational Practices of Building Relationships and Working Collaboratively

Relational practices	Exemplars
Building relationships	<p>First, when you walk into the house, be observant of everything that you see and if you see something that looks special, comment on it. Try to find what's the background story. Try to look at the different narratives of the family—what they enjoy. Talk about their interests. Really work on that relationship in the beginning.... (05-1)</p> <p>[I] realized that if I waited too long to get people involved it was much harder for them to think that their role was important or that their involvement was important. (01-1)</p> <p>There was an alignment there at that point where they were like, "Okay, they are really on our side; they're not with DCF." Like, "They're not against DCF, but they are really here for us." (02-1)</p> <p>Well like with our collaterals, like the referral agencies, you know, we have to have a relationship with them. You know, it has to be a good relationship, or we won't get referrals anymore. (06-1)</p> <p>I take it really seriously and I think it is an honor that they look at our team as a place where they can trust our clinical wisdom, experience, and knowledge; that they are going to go by whatever we recommend; that they can argue and disagree, but we have engaged in a good relationship [with them]. (09-1)</p>
Working collaboratively	<p>As I am doing the treatment plan with them, I really try to put it in their words and try to build on what they are already doing. Finding those solutions. (05-1)</p> <p>But you'll have my support, and I am going to go by what you say, because as far as I am concerned: You are the expert / on your child. Nobody [else] is the expert on your child." (09-1)</p> <p>So I found myself having a lot of meetings and conversations [where] I would ultimately help us all see that we really all want the same thing. "And what is that thing that we all want? Let's all focus on that." (01-1)</p> <p>And so our goal at that point, and my role at that point would be to figure out their desired outcome—figure out everyone's desired outcome. (07-1)</p> <p>Continually working toward unification of the theory and, you know, what is the common ground that we can all share which could only help us collaborate? (10-1)</p>

between the family and other providers as needed, promoting a supportive environment where the family voice can be heard in order to find common ground.

Concluding relational practices. *Building relationships* and *working collaboratively* are two relational practices that support therapists performing their professional roles in HBFT. Working collaboratively relies on a foundation of strong relationships. This applies not only to families, but community partners and stakeholders. Likewise, *relational practices* rely on *communicative practices* to establish rapport and maintain working relationships. It is important to be timely and consistent in engaging in relational practices from the first encounter to the end of services. Proactive and adaptive practices support maintaining relational practices on an ongoing basis. Relational and sustaining practices are mutually supportive. Continuing their commentary on emerging themes as quoted earlier in *communicative practices* and echoing the general consensus, one therapist stated emphatically, “This was the most important in wrap-around services: engaging parents—the communicative, collaborative piece.” (01-2)

Sustaining practices. *Sustaining practices* are concerned with actions that therapists take to care for themselves professionally and personally in order to meet the challenges of their positions. Frequently associated with “finding balance”, these practices directly and indirectly support therapists in managing their different roles and other actions associated with their job. Two sustaining practices that promote balance are *setting boundaries* and *utilizing supports*.

Setting boundaries. *Setting boundaries* is concerned with taking action to establish and maintain professional boundaries within the work setting and between work and personal life. Two dimensions of boundary setting that support managing roles are *clarifying roles* and *managing accessibility*. Exemplars of setting boundaries are shown in Table 4.6.

Clarifying roles is the practice of initiating communication with families and collaterals to establish a clear understanding of role expectations. Taking steps to clarify roles and set clear boundaries at the outset reduces misunderstandings around expectations. Therapists need to be clear about their own role in order to communicate it effectively. Understanding the role of other stakeholders and cultivating an understanding of each other's roles can assist therapists in framing the boundaries of their responsibility when working collaboratively (see *understanding place in the system*). To the extent possible, therapists can employ proactive practices to anticipate potential role confusion so that they are prepared to address them with their clients or other parties. The practice of *clarifying roles* is repeated on a regular basis and whenever there is an incident suggesting that there was a mismatch of role expectations.

Managing availability constitutes setting boundaries around work conditions for self-care and work-life balance. Job expectations, for instance, documentation, travel, the combination of daytime and evening hours, being on-call, and productivity requirements, can erode personal time and family life. Having flexible hours means that therapists have to be proactive about setting a work schedule and establishing routines for handling work that they do from home so that it does not interrupt family life. Likewise, therapists manage their workload to address specific work stressors, particularly around safety and meeting productivity. Approaches to managing availability include advocating with supervisors to restrict or consolidate the caseload to particular regions to make more efficient use of time and taking proactive steps to plan and organize when, where and with whom family meetings would take place.

Concluding setting boundaries. The boundary setting practices of *clarifying roles* and *managing availability* contribute to managing multiple professional roles in HBFT. Therapists recommended establishing clear boundaries for all professional interactions to maintain working

Table 4.6

Exemplars of Two Dimensions of the Sustaining Practice of Setting Boundaries

Sustaining practices: Setting boundaries	Exemplars
Clarifying roles	<p>And I am not going to take your child and fix him and come back. So if your expectation of us is fixing it, that's not going to work, because the only people that can fix this is you, and we will facilitate and support you. (09-1)</p> <p>It's in the beginning [that] you try to discuss appropriate boundaries. (05-1)</p> <p>Clarification with the parents what it is we do and don't do. (03-1)</p> <p>I have always made it clear to DCF that I am not your eyes in the home; that is not why I am there. (04-1)</p> <p>You just have got to maintain professionalism, maintain boundaries, and be able to clearly communicate to families and individuals when they cross those boundaries in an appropriate and effective way. (07-1)</p>
Managing availability	<p>So you need to have your own life; you need to make your own boundaries of when it is appropriate to work and when it is not. (05-1)</p> <p>So I don't come in and first thing tell families, "I can give you rides to places," just because I don't want to be overburdened by that proposal. So I evaluate the situation. (08-1)</p> <p>I think we had to have our phone on 24/7. I actually refused. (07-1)</p> <p>I try to take all my cases geographically in the same location, within a 7-mile radius. I won't take cases outside my comfort zone in terms of where they are. (04-1)</p> <p>So we do have to remind the staff, "If you don't take care of yourself, if you don't take care of your family, you are not going to be good for anybody else. (09-1)</p>

relationships and establish work-life balance. It was noted, however, that there is often institutional (or program) weigh-in on defining expectations about boundary setting. Boundaries are conveyed through *communicative practices*; boundary setting is also managed through *adaptive* and *proactive* practices. Therapists utilize both formal and informal supports (*utilizing supports*) to recognize, define, and maintain appropriate boundaries in the workplace and

between work and personal life. Reflecting on this theme one therapist associated it with being professional, “Because you never know, and you’re professional. And you have to have boundaries in order to remain safe yourself and have your own family and your own life.” (09-1)

Utilizing supports. *Utilizing supports*, another sustaining practice, is concerned with actions taken to connect with others to obtain emotional or practical support in fulfilling the roles of HBFT. Supports are either *formal* or *informal*. Table 4.7 provides a selection of exemplars for the two kinds of support.

Generally, *formal supports* are the direct support provided by the employer or other organization. Most organizations offer supervision and training opportunities for therapists to understand their roles and expectations. Supervision can provide support and guidance around role expectations and managing role dissonance; supervisory support may also focus on identifying how to fulfill roles that therapists are avoiding, for example, case management, administrative tasks, or mandated reporting. Supervision can be isomorphic to desired HBFT practices, particularly when supervisors work collaboratively with therapists to identify existing skills and how to apply them to presenting challenges. Through communicative and reflective practices supervisors can encourage therapists to be reflective and draw on their experience, knowledge and creativity in order to balance and meet expectations to perform multiple roles. Effectively, therapists are encouraged to engage in both/and thinking and adopt a solution-focused orientation to the challenge in the same manner as they approach family problems.

In order to support therapists’ self-care and prevent burnout, many employers draw attention to offered benefits, including health insurance, and vacation packages. Therapists working in supervisory positions may cover for therapists when they need to take a break and stay on the lookout for signs of questionable boundaries. As previously mentioned, HBFT

organizations often provide trainings around self-care and foster developing time management practices to reduce work stress.

Informal supports include co-workers, colleagues and personal family members who support therapists' well-being directly or indirectly. In the work context, approaching more experienced colleagues and peers for feedback on handling workplace culture and practices is supportive. Consulting with peers is reportedly less intimidating than revealing uncertainty or self-doubt to a supervisor. Therapists can also derive support from observing how their colleagues handle roles in different situations. Innovative therapists find ways to take an active role in providing support for colleagues through organizing self-care activities and social events for co-workers.

Having personal social supports at home and in the community helps therapists balance the demands of work with personal life. Engaging in self-care practices and utilizing their support network, as they assist families in doing, helps therapists continue to meet the challenges of working in HBFT. Having understanding partners who tolerate the intrusions of the job, as well as call-out when boundaries between work and personal life are slipping is helpful for therapists in finding work-life balance.

Concluding utilizing supports. Utilizing formal and informal supports is a practice that helps therapists handle the challenges of managing multiple professional roles in HBFT. Taking a proactive approach to obtaining support is recommended when there are doubts about role or role expectations. Making use of formal and informal supports to define roles, meet expectations, and navigate working relationships contributes to feeling supported on the job. For self-care, utilizing supports to find balance between work and personal life is important. The practice of utilizing supports relies on developing communicative and relational practices.

Table 4.7

Exemplars of Formal and Informal Dimensions of Utilizing Supports.

Sustaining practices: Utilizing supports	Exemplars
Formal	<p>When I was confused about roles of I kind of felt like, “Oh, I really want to do more therapy. I want to do more therapeutic interventions, but I feel like I am only just going to the school.” My supervisors were supportive in saying, “Okay, well how can we do that? How can we do more interventions? How can we be more creative? You’re still going to have to go to the school, or you’re still going to have to go to court, or you’re going to have to meet with whoever, but how can we also do the important therapeutic work with the family?” So, I felt supported in that way. (01-1)</p> <p>We received a lot of feedback on our various roles with the various systems. (08-1)</p> <p>So all our supervisors were trained in that, to just say, “Hey, what can I take off your plate? Let’s prioritize this really quick. What can I do to take it off your plate?” So I think it was that support that was the most helpful in maintaining all my roles. (07-1)</p> <p>If I don’t provide good supervision and I don’t get good support then we are really not going to be very clear on our roles... I think it’s a strength that we have to be reminded, “This is our role, this is what we do, this is why we are here.” (9-1)</p>
Informal	<p>It was definitely beneficial observing different peers, different colleagues if you will, with different families and seeing how different everybody could be. (06-1)</p> <p>I think that is probably a good support. I think sometimes it’s nice just to have a peer and not a peer that you’re intimidated by. (02-1)</p> <p>So what else that helps me is my fiancé. If I tell her, “Oh, I am thinking about doing this and this,” she goes, “What are you talking about? No! You need to chill out at home for a bit.” Having supports around me kind of helps me keep that focus. (05-1)</p> <p>Sometimes I am really frustrated and I need someone who kind of understands and just listens to what I have to say without feeling like there is going to be a repercussion.... You need to have a supportive person at home, at work. (12-1)</p> <p>I want to talk about self-care in in-home therapy. I work from home and flex to take breaks and to meditate.... I’m starting a training for other therapists and for therapists to pass on to clients. (05-2)</p>

Concluding sustaining practices. The practices of *setting boundaries* and *utilizing supports* contribute to therapists defining the parameters of their professional roles. These practices together contribute to establishing work/life balance. Facilitated by *communicative practices*, active engagement in *sustaining practices* provides a structure (boundaries) and social support to maintaining *relational practices*. Recommending following the *sustaining practices* outlined here, one HBFT supervisor advises, “If you don’t take care of yourself, if you don’t take care of your family, you are not going to be good for anybody else.” (09-1)

Summarizing cultivating professional agency. Analysis of therapists’ narratives identified common agentic practices that therapists engaged in to handle their multiple roles: I labeled them as *reflective practices*, *communicative practices*, *adaptive practices*, *proactive practices*, *relational practices*, and *sustaining practices*. Reflective practices—therapists’ inner dialogue in response to situations drawing on experiential and theoretical understandings—sets the course, with the other practices emanating from the reflective process. Communicative practices mediate interpersonal connections and information exchange: Effective communication is key to the relational practices of building relationships and working collaboratively as well as the sustaining practices of setting boundaries and utilizing supports. Likewise, communication facilitates implementing adaptive practices and proactive practices. The adaptive and proactive practices are pragmatic approaches to managing different roles in the moment and in anticipation of potential situations, respectively. The proactive practices of planning and organizing provide a frame for being flexible. Adaptive and proactive practices also support relational and sustaining practices.

Each of the agentic practices discussed contributes to effectively managing role changes and the responsibilities associated with multiple roles. When talking about their own self-

identity, therapists also referred to these practices as states of being that they identified with (or aspired to), namely being aware, being communicative, being flexible, being organized, being friendly, being collaborative, being transparent, and being supportive and supported. Engaging in these practices was associated with feelings of self-efficacy. Furthermore, therapists have associated these practices with being professional in HBFT.

Theme 4: *Maintaining professional integrity.* The theme of *maintaining professional integrity* is concerned with the practice of therapists aligning with their professional identity and self-concept as a professional when engaging in agentic practices. Professional identity is reflected through expressions of values, beliefs, perspectives, knowledge and competencies. When reflecting on their role experiences and actions taken, therapists explained their actions through professional frames of reference that were behind their actions. These frames are *identifying as an MFT, keeping an ethical stance, having a systemic perspective, and maintaining a therapeutic perspective*. Additional themes associated with maintaining professional integrity are *acting on values and beliefs*, and *perceiving self-efficacy*. Exemplars of these are provided in Table 4.8.

Identifying as an MFT. *Identifying as an MFT* is concerned with the identity statements made by therapists. Therapists identified themselves as therapists, and more specifically as MFTs or family therapists. In the context of role description, therapists also spoke of themselves as being in-home family therapists or by their job title in addition to being MFTs. Therapists differentiated themselves from their coworkers as an MFT or family therapist, with several noting that they were the only MFT in the workplace or were in the minority. With one exception, therapists reported that being an MFT was a good fit for their existing worldview and

identity. Professional identity as an MFT and having marriage and family therapy training contributes to therapists' ability to manage multiple professional roles.

Keeping an ethical stance. *Keeping an ethical stance* is concerned with meeting ethical standards of professional competence, integrity and accountability. Particularly, this means being accountable to the family and keeping the principles of non-maleficence at the forefront, especially when working with collateral service providers in collaborative partnerships. Being prepared to handle challenges to confidentiality and manage boundaries around disclosures and professional relationships is essential in HBFT. Ethical practice includes being communicative about boundaries and being transparent about role(s) in the professional relationship. Being professional involves maintaining an ethical stance and being extra diligent about adhering to the AAMFT code of ethics.

Having a systemic perspective. *Having a systemic perspective* is a perceptual frame that guides therapists' conceptualization of complex family concerns. In HBFT, therapists need to be attentive to family dynamics and functioning in the home as well as the dynamics that occur between the youth and family and larger systems, for instance with teachers and the school, or with the probation officer and the courts, or with the child welfare worker or other service providers. Systemic understanding provides a frame that helps therapists to engage with the key players involved in the youth's life and assess where and with whom to intervene, for example, with family subsystems or between families and larger systems, and determine what roles are needed to address the task. Having a systemic perspective is relevant when assessing family structure and functioning, and defining treatment objectives to address these. Therapists reported that knowing how to work with multiple family members from a systemic perspective was an advantage that set them apart from colleagues trained in individualistic models. Having a

systemic perspective, as a framework for viewing families and their context, is closely linked to therapists' statements of identity as systems thinkers, or family therapists.

Maintaining a therapeutic perspective. *Maintaining a therapeutic perspective* means working from an understanding of theory and using it to inform the rationale for interventions. This involves letting go of preconceptions of the clinical role and recognizing what interventions might be most therapeutic in the moment. By aligning themselves with the treatment goals, therapists can stay connected to the therapeutic objective of their work. Reframing goal-oriented processes as therapeutic helps therapists to discover how different roles could be practiced from a therapeutic perspective. With experience, these processes are integrated in practice and roles and actions are seen as informed by theory and the treatment goals.

Having a therapeutic perspective helps integrate roles that were previously considered to be separate from therapy. For instance, finding a therapeutic purpose for administrative tasks helps to relieve frustration with the role; utilizing formal assessments in session as therapeutic tools can counteract feeling that the task interrupts the therapeutic flow. Likewise, case management or advocacy tasks is reframed as therapeutic when the family is engaged in the process. Several therapists reported that engaging and empowering families to call or meet with other providers in session is a therapeutic intervention, contributing to developing autonomy and self-confidence; in making this part of their practice they did not really differentiate the case management role from therapy.

Regardless of the expected roles of that they might be asked to perform on the job, therapists returned to their basic identity as a therapist as the legitimate role that informed all other roles. In doing so they referred back to "my real role as a therapist" (05-1) or stated their position in relation to other roles: "first and foremost I am their therapist." (10-1) To support this

positioning, therapists used theoretical objectives and the goals of therapy as a frame for staying connected to their therapeutic role.

Table 4.8

Exemplars of Therapists' Orientations for Maintaining Professional Integrity.

Maintaining Professional Integrity	Exemplars
Identifying as MFT	<p>And then of course being a marriage and family therapist... (06-1)</p> <p>I think being a family therapist is definitely—it makes it easier. (10-1)</p> <p>But as an MFT I was hyper-aware of being in the minority in the work setting. (11-2)</p>
Keeping an ethical stance	<p>But what happens is that we as clinicians have this code of ethics and this is how we do things.... (09-1)</p> <p>Ethically my obligation is to do whatever is in the best interest of my client. (01-1)</p> <p>You kind of have to play it by ear and look at your ethical stance, “Am I crossing this line? Is this a boundary that could get me into trouble later on?” (05-1)</p>
Having a systemic perspective	<p>I think for me just realizing having been trained in therapy and having this approach and lens. (01-1)</p> <p>But to be honest, thinking systemically and being a family therapist. (07-1)</p> <p>I feel like the way we work sometimes we’re able to see the whole picture and really dig deeply into people’s lives. (02-1)</p> <p>But basically there is an understanding of, “I am treating you guys as a family so even though the youth is my identified client who I do paperwork for, but in my mind the family is the one I am treating....” (08-1)</p>
Maintaining a therapeutic perspective	<p>The common language amongst providers was what could be therapeutic: you could be therapeutic in so many more places than I previously imagined: going into the schools, meeting at camp, et cetera. (11-2)</p> <p>Using the theory as the base you can be creative how you intervene, for instance taking kids into the woods to experience the quiet and things like that. (02-2)</p> <p>I think in the back of my mind for all my clients on a relational level I say, “This is the goal of therapy.” (01-1)</p>

Acting on values and beliefs	<p>It's kind of like being flexible, or being able to roll with the punches or go with the flow. I think that is definitely a quality that serves me well in this job. (02-1)</p> <p>It was having to maintain a level of accountability. It becomes part of your identity: not only meeting the bar but continuing to do it to reach a higher standard. (01-2)</p> <p>I try to be very fastidious with my paperwork; it is just a personal point of pride with consistency. (03-1)</p> <p>You have to be committed to really being humble and really being able to be professional at all times. (07-1)</p> <p>Being a good steward as a therapist. Trying to do my best. This is a personal core value. (01-2)</p> <p>So when a human being like us has been called to what I feel is this sacred field it is humbling; but for some reason you have been called. (09-1)</p>
Perceiving self-efficacy	<p>I felt like I really got to be a little bit more effective in a lot more areas because they are all so interconnected and effected by one and another. (01-1)</p> <p>Being experienced now, I kind of get the vibe right away. (03-1)</p> <p>You know, it was so easy, so much easier for me to see and discover those key drivers and work with the family more hands on. (07-1)</p> <p>But in this instance there was just too much in front of me to ignore in terms of what I saw with the dynamics and I was like, "No, I think I have the skills and know-how to engage." (11-1)</p> <p>Quite frankly I have been doing it long enough that I can usually handle it. (12-1)</p>

Acting on values and beliefs. The values and beliefs that therapists bring to their practice are individual factors that support the agentic practices that they employ to manage professional roles. Values, like being trustworthy, punctual, consistent, and efficient are requisite professional attributes that are associated with proactive and relational practices. Other values, like being flexible, creative, humble, and easy-going are considered dispositions relevant to HBFT, particularly adaptive and relational practices. Values that support reflective practices include being mindful or present, curious, observant and introspective. Being respectful and empathic

and embracing orientations—such as being communicative and collaborative—supports communicative and relational practices,. Several therapists' framed their work as a calling, stewardship, or sacred work; this was in keeping with their social justice values and was internally supportive as a sustaining practice.

Perceiving self-efficacy. *Perceiving self-efficacy* is concerned with therapists accounts of incidents and experiences where they feel confidence in their ability to perform HBFT roles and responsibilities effectively. Previous training and life skills as well as on-going learning experiences are factors that contribute to perception of self-efficacy. Both educational and lived experience may contribute to the perspective that in-home services are an obvious location to intervene in peoples' lives. Having life experiences that normalize entering into people's personal space with respect often contributes to feeling comfortable working in other people's homes. Perceptions of self-efficacy may also be attributed to skills brought in from previous work positions. Therapists with previous experience working in residential settings or as a paraprofessional in HBFT reported that this had prepared them to handle many of the interpersonal challenges that their colleagues struggled with when working in the home. Other therapists drew upon skills, like organizational time management, they had developed in other professional careers.

Beliefs in self-efficacy are revealed in assertions of having both experience and the knowledge, the skill, or the understanding to manage job expectations; expression of lacking self-efficacy is often attributed to inexperience or skill-deficits. However, reports of self-efficacy are not limited to experiencing role congruity: Therapists commonly reported feeling self-efficacy after effectively managing situations where they had initially experienced role dissonance. Therapists' appraisal of self-efficacy with regard to HBFT roles and responsibilities are generated

through cultivating reflective practices and engaging in practices of professional agency.

Concluding *maintaining professional integrity*. When reflecting on role experiences, therapists draw on personal frames of reference that guide them in decision making and engaging in agentic practices. The different frames of reference reflect therapists' personal professional identity—the voice of “who I am” and “what I do” — explaining their actions. Professional integrity is predicated on acting according to personal values and beliefs. Therapists' role experiences are filtered through this lens, resulting in appraisals of dissonance, congruity, and perception of self-efficacy. When managing institutional expectations, job satisfaction is sustained by working in alignment with personal professional integrity.

Theme 5: *Being professional in HBFT*. In order to manage multiple professional roles, it is necessary to be professional and maintain a professional presence. Therapists' discourses about being professional addressed roles, identity as a professional, and professionalism as a status to be maintained or balanced. The themes of *understanding place in the system*, *having role experiences*, *cultivating professional agency*, and *maintaining professional integrity* each have a pragmatic connection with what it means to be professional in HBFT. The agentic practices outlined in *cultivating professional agency* correlate with therapist and institutional narratives of desirable professional behaviors.

Defining professionalism. At first glance, therapists' definitions of professionalism in HBFT were contradictory. Explanations of professionalism revealed intersections between institutional definitions of professionalism and the individual's professional identity, incorporating their education, professional and life experiences. These intersections often reflected what seemed to be, at first glance, conflicting views of what professionalism in HBFT was. That is, many therapists offered a composite view of professionalism incorporating

professional practices from their professional experiences and training as an MFT as well as the professional expectations of their work environment in contradictory terms. At first a therapist might assert (as most did) that they has to do their best to maintain professionalism, but then follow up with qualifying remarks suggesting that “You can’t always be too professional” (02-1) or more directly, “...there isn’t much room for being professional in in-home [therapy].” (10-1) This apparent contradiction is explored through examination of examples of how therapists approached translating their understanding of professionalism in HBFT into practice.

Defining professionalism as conduct. When therapists spoke of being less professional, this was frequently in reference to aspects of professional presence that are considered to be different in HBFT from outpatient or private practice settings, primarily with respect to dress and therapeutic positioning. Therapists reported making adjustments to their professional presence in the home in order more effectively connect and join with families (*adaptive practices*). As mentioned above, therapists modify how they present themselves to families by being attentive to how they dress; in doing so they are also mindful of their public visibility as a therapists in the community. While the dress code for HBFT is more casual, it is not so casual that therapists would be seen as unkempt or disrespectful to the family and “the profession”. Therapists take into consideration family culture and client expectations when dressing for home visits, but also take into consideration whether they would also be attending meetings at court or in the school.

Being a professional working in the home environment also means making adjustments to therapeutic positioning. When some therapists spoke of being less professional in the home setting, they often were referring to being more laid back and less clinical in their approach. Other therapists framed having the maneuverability to adapt to the setting by adjusting their therapeutic positioning and approach as a professional skill that was suited to HBFT. In response

to the question, “What does it mean to be professional in HBFT?” one therapist laughed as they explained the steps they took to position themselves when working in the home while being mindful of their attitude and approach:

It is not coming all dressed up thinking I can take care of everything. When working in the home it is keeping boundaries about what to engage in as far as activities. I tend not to challenge as much. I am delicate with handling underlying issues, I don't want to disrespect, and I will try to alter my phrasing, my timing. I may wait for the person to come back when they are wanting to talk about it. It is letting the client lead, maybe hint where you want to go; respect the client. (05-2)

In this definition of professional behavior, therapists set boundaries, laying a foundation for engaging and building rapport with others by calibrating their interactions, as well as making adjustments and privileging the family voice. Therapists act on values of respect and humility, following a flexible plan that allows the family to take the lead. With the exception of utilizing supports, nearly all the agentic practices are covered in this description of being professional. Being professional is being attuned to the requirements of the different roles and making adjustments accordingly.

Defining professionalism as a role. In the field of HBFT therapists have often defined their roles in terms of being guests and visitors in the home. The guest/visitor framework supports a humble, respectful, client-centered orientation. From this position, therapists are more casual and friendly, working with families from a one-down position. At the same time, this orientation is not intended to preclude being professional: in practice it is subsumed into the professional role. In order to make this point, one therapist made the distinction between being a friend and a “professional friend”, establishing their role as being a professional:

The way we work with families we are.... It seems we are enmeshed but we are not, because we know that we are like a friend, but we are not the friend. You are a professional and this is your role and your duty. (09-1)

By incorporating the visitor/guest perspective into the professional role, therapists remain connected to the role expectations and their professional skills. This role clarification is made both to oneself and to the families receiving services: "I don't consider myself a guest.... I see myself as a provider in your home." (04-1) Framing being professional as a role helps establish boundaries around the relationship despite its being more casual than in the office.

Institutional expectations. Another explanation offered to explain lack of clarity around what it means to be professional in HBFT is tied to institutions and programs having different expectations of therapists' roles in service delivery. Accordingly, therapists perceive them as different from expectations they may have experienced in outpatient settings; expectations of professional behavior varied across settings according to the HBFT program and organizational mission. The value of knowing institutional expectations has already been addressed in *understanding place in the system*. Here we are looking at the institutional narratives associated with professionalism.

Institutional expectations are the professional standards set by the organization running the HBFT program: expectations of professionalism are imbedded in the company culture and are communicated to employees with varying degrees of specificity. Institutional and program policies set boundaries around role expectations, expected professional dispositions, and the management of collateral relationships. The majority of therapists identified institutional standards as setting (or program)-specific expectations that had to be learned on the job. In line with this argument, one therapist noted, "I would say that I feel like professionalism training and

professionalism experience tend to be both taught and experienced as very setting-specific.” (10-1) Professionally, therapists are expected to align with the organization’s mission statement in their actions. One therapist explained how their organization set a standard of professionalism for therapists’ interactions with families that was to be extended to providers, and community partners as well:

And then our responsibility was to—they really emphasized, and I also appreciated this—was just being very professional and having a ton of professionalism while out in the community, when meeting with families: Almost having that like customer-service mentality was really big for this company. (07-1)

Being professional in the community means being mindful of culture and context in their interpersonal interactions with families and other community partners (*understanding place in the system*). It also means developing working relationships with key players in the larger systems involved with the families (*relational practices*).

Employees are expected to follow program guidelines for professional conduct as well as adhere to their code of ethics. A review of HBFT job descriptions revealed professional attitudes or dispositions that institutions expected therapists to have in order to maintain a professional presence. With respect to time, therapists need to be punctual, reliable, and efficient.

Interpersonally, they should be culturally sensitive, friendly, respectful, empathic, and trustworthy; they are expected to be collegial and team players. Therapists are expected to be accountable for their actions (*reflective practices*), organized (*proactive practices*) and communicative (*communicative practices*). Other attributes, like being flexible, creative, open-minded, and easy-going are considered dispositions relevant to the job (*adaptive practices*).

Institutional professional expectations are further defined by program models. There is an

expectation that as professional therapists, they would be knowledgeable about relevant treatment approaches and/or willing to learn the program's designated treatment models. As professionals, therapists are expected to adhere to the model's treatment protocols and demonstrate efficacy of treatment. The program or treatment model defines the therapists' role responsibilities and expectations. Although this was not always explicitly stated in the job descriptions, therapists are expected to wear many hats and be flexible in managing these different roles and responsibilities.

Individual standards of practice. Therapists frequently distinguished between the institutional expectations of professionalism and their own individual standards of practice. These standards have already been introduced with the theme of *maintaining professional integrity*. Therapists bring values and standards to their understanding of professionalism that are informed by their family therapy training and life experiences. In the interviews, all therapists located their graduate training in MFT as formative to their professional identity development. Graduate school was also where the values and ethical practices that inform MFT standards of practice are learned. Having family therapy training is considered foundational to being professional in HBFT as it provides familiarity with theoretical models for family work and an understanding of how to intervene in systems. On a personal level, therapists identified as professional the personal attributes and professional dispositions typically sought after by employers, particularly being respectful, empathic, and trustworthy to name a few.

Adhering to the AAMFT code of ethics was identified as the primary standard for professional practice for MFTs. Therapists reported that they had conceptually learned about use of self in therapy, handling family secrets, boundary setting and roles while in graduate school, setting the foundation for ethical practice with families. For many therapists, having ethical

standards is just one spoke of a larger wheel of values associated with being professional. One person noted that being professional meant acting with common sense: “You are a fair person and you are a decent human being with good ethics.” (10-1) On an individual basis, being professional reflects having a sense of social justice. Several therapists spoke of their professional role as a calling, or as moral duty to the community; being professional reflects being true to these values. (*maintaining personal professional integrity*).

Concluding *being professional in HBFT*. Professionalism involves overlapping standards of practice viewed from individual and institutional perspectives. Therapists’ role experiences (*having role experience*) suggest that, while overlapping, these standards are not always in alignment. In principle, being grounded in the code of ethics and following ethical standards of professional competence, integrity and responsibility to clients is supported by both therapists and employers. Likewise, therapists and employers identified similar attributes and dispositions as important to HBFT work. Assimilating and integrating different perspectives on professionalism is an ongoing process as therapists become acculturated in HBFT services. Adapting existing conceptualizations of professionalism to working in HBFT programs is also part of learning on the job. As one therapist (10-1) reflected, “You as a therapist need to work on what it means to be professional.”

Integrating the themes into a practice model. Analysis of the narratives of 12 MFTS who have collective experience providing HBFT to youth and their families in the home and community produced five themes that are relevant to how therapists manage professional roles in HBFT. The themes are *understanding place in the system*, *having role experiences*, *cultivating professional agency*, *maintaining professional integrity*, and *being professional*. Although I focused on the theme of *cultivating professional agency* as a core category, it can be said that all

the themes are concerned with what it means to be professional in HBFT.

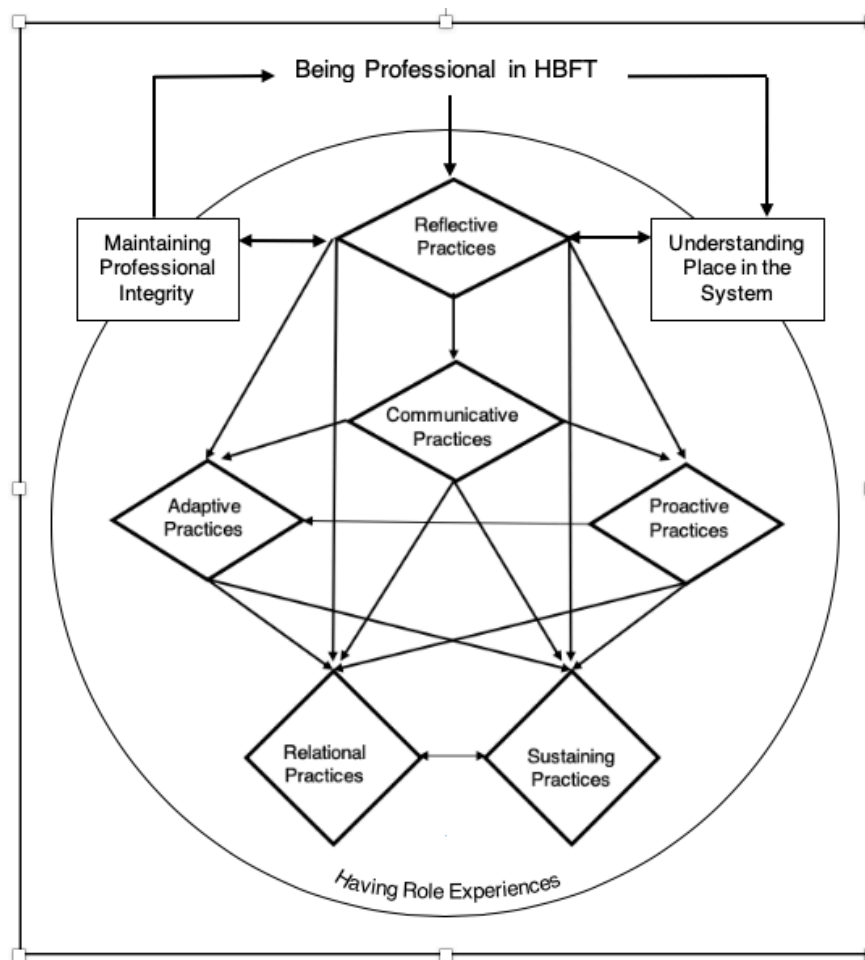


Figure 4.2 Connecting the themes *being professional* and *cultivating professional agency*

Being professional in HBFT, involves *cultivating professional agency* through *reflective, communicative, adaptive, proactive, relational* and *sustaining* practices. Reflective practices, in response to *having role experiences*, and informed by *understanding place in the system* and the frameworks associated with *maintaining professional integrity*, lend motion to the other agentic practices. These themes can be brought together to provide a pragmatic approach to managing multiple professional roles in HBFT. A visual representation, expanding on Figure 4.1, illustrating the relationships between the five themes and the domains of agentic practice, is given in Figure 4.2.

Reflective practices are considered as the switchboard for the other agentic practices; one therapist described the elements of reflective practice as steps taken in order to “stay on track” (01-1). The *reflective practices* of *cultivating awareness*, *assessing experience*, and *formulating action* are introspective responses to *having role experiences*. Through *cultivating awareness* and *assessing experience* in the moment, therapists tap into their implicit and conceptual knowledge from education and life experience and build on their understanding of their place in the system, role experiences, and the integrity of their professional knowledge, skill and values. When faced with role dilemmas, besides *acting on values and beliefs*, therapists connect with the stances detailed in *maintaining professional integrity*, particularly *keeping an ethical stance*, *having a systemic perspective*, and *maintaining a therapeutic perspective*. Therapists’ *identifying as MFTs* are positioned through their family therapy training to act from an ethical, systemic, and therapeutic orientation that aligns with their professional identity.

Through *cultivating awareness* therapists develop an *understanding of place in the system*. For therapists, the process of learning how to manage multiple professional roles, is as much about developing a competency in systemic cultures through *knowing regulations*, *understanding institutional culture*, *understanding collateral systems*, and *understanding family culture*, as it is learning how to apply their theoretical understanding in new environments. *Understanding place in the system*, particularly the expectations associated with their roles, primarily comes through *learning experientially* on the job.

Learning experientially is derived from on-the-job trainings, *having role experiences*, and *utilizing supports*, both *formal* and *informal*. Therapists learn by observing, by doing, and then following reflection, adjusting as needed. Role experiences that inform therapists’ learning fall into the categories of *experiencing role congruity* and *experiencing role dissonance*. Notably, the

different manifestations of the latter category, namely *feeling role conflict*, *juggling different perspectives*, and *blurring of boundaries* are more emotionally charged, but therapists' description of their resolution provides clear examples of the agentic practices described. As a category, *experiencing role congruity* reflects instances of therapists *perceiving self-efficacy*. By all accounts, *having role experiences* offers a changing landscape with ongoing reframing of what it means to be a therapist in HBFT coming from new experiences. For therapists *experiencing role congruity* the distinction between roles becomes less significant with increased role clarity.

Therapists experience the intensive experiential learning process as transformational, resulting in personal growth and *perceiving self-efficacy*. Describing how *learning experientially* amid changing institutional policies contributed to their self-concept, one therapist commented, "And [there are] lots of changes and then trainings to follow up with those changes. So that helps kind of build you as a good therapist as you try it with seeing people." (06-1) Referring back to *reflective practices* as a process, another therapist identified the combination of awareness, questioning, and informed experiential, theoretical, and value-based action as "being intuitively educated." (09-1) *Perceiving self-efficacy* in managing multiple roles is anchored in *maintaining professional integrity*. That is, self-efficacy in HBFT is supported by *having a systemic perspective*, *keeping an ethical stance*, and *maintaining a therapeutic perspective*.

Therapists responses to role experiences are generally mediated through *communicative practices*. With respect to managing roles, therapists engage in three types of conversations, namely *explanatory conversations*, *transactional conversations*, and *dialogic conversations*. Effective communication between therapists and others is a key component of managing multiple professional roles as well as a professional attribute. Being communicative is a value

associated with professional identity development. One therapist, with limited experience in HBFT, indicated that communicating with other systems had not been included in their MA training experience and was part of the acculturation process as they became familiar with HBFT practices through *understanding place in the system*, while other therapists reported drawing on other life experiences to complement their education.

Managing multiple roles and handling role expectations was largely the focus of *sustaining practices*. Professionalism in HBFT involves *setting boundaries* through the practices of *clarifying roles* and *managing availability*; these practices are critical to *relational practices*. *Setting boundaries* and *utilizing supports* provides encouragement and reinforcement of meeting role expectations. *Formal* support is obtained from supervisors and trainers; *informal* support comes from colleagues and peers as well the therapists' personal support system outside of work. Pairing conversations from *communicative practices* with *sustaining practices*, therapists clarify expectations in the work setting and take steps to establish boundaries between work and their personal life. Reflecting on the intersection between *learning experientially* and *utilizing supports*, one therapist remarked that, "I think really helped me grow and understand what I can and cannot do and what my boundaries are, what my limits are as a person and as a therapist." (07-1)

Relational practices rely on the quality, clarity, and frequency of *communicative practices*. The relational practices of *building relationships* and *working collaboratively* depend on therapists' ability to engage and maintain rapport with others. *Building relationships* is facilitated by being communicative and *working collaboratively*. In collaborative practice, the importance of *privileging family voice* and working towards *finding common ground* are guiding principles. *Understanding family culture*, particularly through being able to take into account

cultural values, intergenerational stories, and relationships with other systems, facilitates *building relationships* with families. In a similar manner, *understanding collateral systems* facilitates *building relationships* and *working collaboratively* with stakeholders and other professionals.

Through the *proactive practices* of *planning* and *organizing*, therapists are proactive in managing their time and being prepared for different roles. Attending to *planning*, namely, having a plan for handling multiple contingencies, gives therapists the flexibility to engage in the *adaptive practices* of *adjusting* and *accommodating*. The practice of *organizing*, particularly through time management, provides a scaffold for *accommodating* and *going above and beyond*. *Adjusting* and *accommodating* assist with *building relationships* and *working collaboratively*. In terms of *working collaboratively*, the practices of *organizing* and *communicative practices* are particularly relevant in terms of getting everyone together on the same page so that they can work towards *finding common ground*.

Therapists' definitions of *being professional* reflect overlapping influences from institutional expectations, understandings of HBFT values, and personal professional identity. Professionalism in HBFT is being accountable and mindful of MFT ethical standards. Professional practice calls for therapists to know their roles and proactively communicate them to reduce confusion around expectations. Professionalism is maintaining professional boundaries, including managing confidentiality, and maintaining work-life boundaries for self-care. Being professional involves working on building alliances with families and collaborative partners and taking measures to maintain rapport. It requires having a professional presence, with regard to dress and punctuality, and cultivating dispositions like respect, humility, curiosity, trustworthiness, and empathy. Finally professionalism involves embracing the values of HBFT,

including family-centered care, meeting families where they are, and having a strength-based, solution-focused orientation.

When therapists are proactive in communicating with others, through clarifying roles and expectations, setting boundaries, and making use of supports, they encounter fewer issues managing multiple roles. Being clear about their own role, as well as the roles and perspectives of families and collaborative partners, helps with communicating expectations and working collaboratively towards shared objectives. These collaborative partnerships between families and providers calls for a relational approach with emphasis on engaging and maintaining rapport. Managing multiple roles is aided by being organized and planful, while at the same time having the flexibility to adjust or change roles in the moment and accommodate when needed. Being mindful and aware of these practices helps therapists navigate between their multiple roles in order to meet the needs of multi-stressed families at home and in the community with professionalism.

CHAPTER 5

Discussion of the Results

At the outset of this research, when the question was posed to potential participants, “How do MFTs manage multiple professional roles in HBFT?”, the topic was met with both curiosity and enthusiasm as a topic of common interest. Twelve MFTs with experience in HBFT, participated in interviews with the researcher, contributing their knowledge and expertise to the construction of a pragmatic model of being professional and cultivating professional agency to manage multiple roles in HBFT. Six agentic practices were identified as relevant to managing professional roles, labeled as reflective practices, communicative practices, adaptive practices, proactive practices, relational practices, and sustaining practices. For therapists, being professional in HBFT involves therapists understanding their roles and maintaining personal professional integrity, as well as having an understanding of the respective cultures of the institutions, professionals, and families they were working with.

Based on my findings, I propose that in HBFT practice, therapists manage multiple professional roles through engaging in reflective practices and exercising professional agency. In pursuing this position, I offer an alternative frame from the research that has treated HBFT therapists’ role dilemmas as evidence of requisite competencies in need of development and/or training (see Adams & Maynard, 2000; Christensen, 1995; Macchi & O’Connor, 2010; Quinones, 2013; Stinchfield, 2004; Tate et al., 2014). In line with my findings, I suggest an frame in which managing multiple professional roles is considered an emergent process and professional orientation: Therapists reflect, respond, and learn from role-related situations as they arise in their work, even after having achieved a level of competency. In this model, therapists are actively engaged in managing their roles to meet the needs of the moment,

experiencing different degrees of self-efficacy as they do so. This process of active engagement can be understood as being professional.

The particular concerns about roles and boundaries as voiced in the literature, for example, role conflict, role confusion, blurred boundaries, and so forth, were recognized by the participant therapists as they accounted for both challenging and rewarding role experiences (compare Christensen, 1995; Roberts 2006; Worth & Blow, 2010); however, whether or not it was ethical to have multiple roles was not voiced as a major concern for the therapists interviewed in this study: that is, while they saw potential ethical concerns, as related in *having role experiences* in Chapter 4, they generally had the means to address them as they came up and proactively engaged in practices that forestalled ethical situations. For the most part therapists resolved role challenges through agentic practices, with one therapist pointing out that, “I don’t necessarily see it as an ethical issue until a boundary is crossed.” (02-1) Rather, therapists were adamant that the bottom line in managing multiple roles was working for the family (client) and seeing that the family voice was heard. Following the paths that therapists articulated to illustrate challenges and successes performing different roles in HBFT, I was struck by the creativity and flexibility demonstrated in navigating multiple allegiances and social demands. Although specific challenges were raised where therapists reported experiencing role dissonance, the situations were counter-balanced by their agentic actions, including refining their understanding the parameters of their role(s). Therapists who had been working in HBFT for some time were more likely to report that they saw themselves moving easily between roles, or even that they had integrated them, so that they felt like multiple facets of the therapeutic role.

Initial corroboration of the findings of this study can be located in a 1999 study of MFT interns transitioning from outpatient to home-based practice research (Snyder & McCollum,

1999; Thomas et al., 1999). Although these articles, based on a study shared by two university training programs, were principally focused on presenting a model of the developmental process of learning HBFT, their study foreshadows the agentic practices and other themes of this research. The researchers reported that the participating interns learned to adjust their perception of therapy through reflective practices and developed strategies to handle their role dissonance when working with collaterals and seeing families in the home (Snyder & McCollum, 1999; Thomas et al., 1999). Although connections were not anticipated at the start of this research, the corroboration of reflective practice as a dimension of experiential learning and cultivation of agentic practices lends strength to the present study. Following a discussion of professionalism, I will return to this study to demonstrate how the present study can be seen as expanding on the findings of this early research to create a model of professionalism and professional agency in HBFT.

Professionalism and Maintaining Professional Integrity

When the topic of managing professional roles was discussed, it brought views about professionalism and being professional to the fore. Although there was some ambiguity in defining what it means to be professional in HBFT, therapists' perception of professionalism incorporated elements from institutional, personal, and professional (e.g. AAMFT ethical code, MFT training) narratives. Therapists' conceptualization of being professional as manifesting certain dispositions, behaviors, and/or role(s) reflected some of the circulating discourses associated with the term. The multiple definitions of professionalism are echoed in the literature where different categorizations of what it means to be professional abound. In a review of the literature on professionalism in the mental health field, Aylott, Tiffin, Saad, Llewellyn, and Finn (2018) distinguished conceptualizations of professionalism on an individual level from societal

level definitions. The individual level that concerns us here incorporates *intrapersonal professionalism*, namely working in alignment with the profession's core values; *interpersonal professionalism*, demonstrated by relating and communicating with others appropriately; and *working professionalism*, taking action by selecting appropriate behaviors for the situation through reflection, critical thinking, and situational judgment (Aylott et al., 2018, p. 11).

Instead of defining professionalism as a list of competencies, Aylott et al. (2018) proposed that it is conceptualized as a “latent trait”, situationally manifested in behaviors that “demonstrate a commitment to ethical practice, cultural-sensitivity, self-awareness and reflection and self-discipline” (p. 13). The findings of my study, which suggest that professionalism is demonstrated through cultivating agentic actions while maintaining professional integrity, are congruent with the argument that professionalism is a situated construct that is dependent on self, context, and, by extension, appropriately managing professional roles (Aylott et al., 2018).

The research themes of maintaining professional integrity, understanding place in the system, and cultivating professional agency as professional practices are corroborated by the three categories of professionalism as defined in Aylott et al.'s (2018) review. Maintaining professional integrity, particularly in the domains of ethical adherence, accountability, and commitment to evidence-based practices reflected intrapersonal professionalism through working in alignment with the professions' core values. Relational and communicative practices reflect the category of interpersonal professionalism, namely the ability to engage and relate to others, develop quality relationships, and communicate effectively (Aylott et al., p. 10). Aylott and colleague's definition of working professionalism, defined as the ability to “make appropriate judgments in times of need, applying critical thinking, reflections, and situational judgment” is supported in this study by reflective and sustaining practices informed by therapists

maintaining professional integrity (p. 11). This dimension is particularly relevant to the present study as it concerns the therapists' flexibility to juggle different perspectives in reflective practice, using judgment to act in the best interests of the client based on the situation.

Reflective practices and working professionalism. Professional judgment is reached through internal dialog in reflective practice, informed by experience, contextual and cultural understandings, and the different positionings associated with maintaining professional integrity. The reflective practices of cultivating awareness, assessing or questioning the situation, and formulating action align with the underlying principles of Schön's (1983) epistemology of professional practice espousing reflecting-in-action. For the therapists in this study, reflective practices informed actions taken. This is supported by existing research that posits that engaging in reflection in response to role experiences where uncertainty and value conflicts come up promotes professional behaviors (Aylott et al., 2018; Geijssels & Meijers, 2005; Schön, 1983). The dimensions of reflective practice as defined in this study are similar to the findings of Rober, Elliott, Buysse, Loots, and De Corte (2008), who explored the dimensions of therapists' inner conversations between the "experiencing self" and the "professional self" (p. 407). Rober et al. (2008) identified attending to and processing the (client) situation, having awareness of internal experiencing, and managing the therapeutic process as four dimensions of the reflecting process that inform the therapists' position (role) and agency (p. 417). This inner dialogic conversation is very much a part of collaborative therapy practice (see Anderson & Goolishian, 1988, p. 383), although this was not a model that participants overtly identified with in this study.

A situated professional identity. Professionalism in HBFT incorporates institutional expectations together with therapists' internalized professional values and practices assimilated from their training as MFTs. In this regard, being professional is aligned with professional

identity, which is conditioned by workplace and program influences over time, and identification with the HBFT job. The relevance of both contextual (workplace and working environment) factors, and personal professional factors, including professional identity, knowledge, and experience, to understanding professionalism and professional agency is supported by Eteläpelto, Vähäsantanen, Hökkä, and Paloniemi's (2013) subject-centered socio-cultural framework for understanding professional agency. Their model allows for the renegotiation of professional identities as professionals move from one job to another, reflecting what therapists in this study have suggested, namely that professionalism is sensitive to context and has to be (re)learned to meet specific job expectations. Reflective practices, as a means of transforming and translating role experiences into professional knowledge, contributes to experiential learning (see Kolb, 1984; Schön, 1983). Geijssel and Meijers (2005) posited elsewhere that addressing boundary experiences with reflective practices fosters identity learning. The development of professional practices and HBFT role identities through experiential learning on an ongoing basis as related in my study, is compatible with Eteläpelto et al.'s (2013) framework which situated these processes as negotiating and constructing identity positions (p. 61). In keeping with the therapists in this study reporting having a plurality of role identifications, both personal and professional, that informed their professional actions, other researchers including Stronach, Corbin, McNamara, Starke, and Warne (2002), have found that professionals appeal to their personal professional identity when explaining what it means to be professional, by referencing their approach, style or professional orientation. In the present study, identifying as an MFT, having family therapy training, and having grounding in the AAMFT ethical code, are different facets of professional identity and strengths that help therapists manage their professional roles. This is consistent with

other studies that have located professional identity as a reference point for performing professional roles (Alves & Gazzola, 2013; Stronach et al., 2002).

Complimenting this picture, therapists revealed that they often filtered their multiple roles through the lens of their MFT identity to reorient when they were adjusting or adapting to other roles. Having systems training and gaining competence in understanding the different system they collaborated with is highly relevant for MFTs working with eco-systemic models. Locating their professional identity in the context of work and life experience concurs with Alves and Gazzola (2013) who included work setting and work experience, education and training as most important to professional identity formation.

Capturing this multi-faceted description, Stronach et al. (2002) suggested that the professional is not a type that can be categorized in the singular, but in terms of the plurality of roles performed was better represented as mobilizing multiple “identifications in response to shifting contexts” (p. 116). With regard to this argument, in reviewing the HBFT literature it is notable how often the therapist was treated as a singular identity who encountered dissonance when called upon to perform other roles like case management or advocacy (see Adams & Maynard, 2000; Snyder & McCollum, 1999; Stinchfield, 2004). An exception to this singularity was Jager et al.’s (2009) study which pointed out the “multifaceted nature of the construction of MFT professional identity” (p. 48) as involved in therapy, advocacy, and multidisciplinary collaboration. Reflecting on the broader role expectations in professional practice, therapists in the present study conveyed a spectrum of role identifications, with some therapists reframing the multiple roles as folded into one identity, that could be called out as needed; others located them as positions that could be switched in the manner of hats (compare Quinones, 2013). At the same

time, however, there was still a distinction between roles, as the therapists also described coming back to their core identity as a therapist or MFT.

When accounting for role experiences in HBFT and perceptions of self-efficacy in managing roles, the challenges are frequently associated with having to navigate different allegiances. The tensions encountered by therapists juggling their perceptions of familial, supervisory, and institutional expectations in line with their personal professional integrity are consistent with what Stronach et al. (2002) called “ecologies of practice” (p. 122). In ecologies of practice, professionals experienced a split between the separate allegiances to the different layers of accountability of self, management, licensing boards, regulatory bodies (Stronach et al., 2002, p. 120). In the latter study of teachers’ and nurses’ discourses about being professional and professionalism, professionals appealed to their personal professional orientation in much the same way that the therapists in my study did by referencing their approach, style, or professional orientation as an identity position.

Professional Agency in Practice

Besides maintaining professional integrity, professional roles are managed through *cultivating professional agency*. In talking about their work, agentic practices and personal professional identity are often used interchangeably as a manner of being or a chosen stance. Eteläpelto et al. (2013) proposed defining professional agency as “practiced when professional subjects and/or communities exert influence, make choices, and take stances in ways that affect their work and/or their professional identities” (p. 61). Therapists’ professional identity reflects the stance they speak from, for instance in talking about a situation, they may assert their identity as an MFT or as an in-home therapist. Therapists in this research not only drew on work experiences to act professionally but also directed personal life and non-MFT work experiences

towards finding professional agency in HBFT. In a study that explored therapists' and clients' experience of engaging in HBFT, clients reported finding therapists who spoke from life experience more relatable and trustworthy, a factor that improved the therapeutic relationship (McWey et al., 2011).

Competencies and cultivating professional agency. As stated earlier in the chapter, previous researchers have considered the development of professionalism in HBFT as the mastering a set of skills or competencies. The findings in this research suggest an alternative view where therapists engage in agentic practices to manage professional roles. While the agentic practices, when nominalized as a competency, appear to be related, generally previous research has focused on competencies that were relevant to HBFT generally, but had not directly addressed which competencies contributed to managing professional roles successfully. Taking this into account, comparing the findings to the literature calls for a degree of caution as some of the previous studies lack specificity in this domain. With the exception of Snyder and McCollum (1999) and Thomas et al. (1999) support for the different themes can be found piecemeal in other research.

Returning to the MFT study mentioned earlier in this chapter, I will look at the ways that it can be shown to corroborate the agentic practices defined in the present study (Snyder & McCollum, 1999; Thomas et al., 1999). Beginning with locating reflective practices in experiential learning, the researchers reported that the participant interns were trained in reflective practices modeled after Schön's (1983) "frame experiments" (Snyder & McCollum, 1999, p. 231). Reflective practices and utilization of formal supports throughout the learning process resulted in increasing experiences of self-efficacy (Snyder & McCollum, 1999; Thomas et al., 1999). The researchers identified intern concerns with boundary blurring and conflicting

perspectives as principle issues associated with feelings of dissonance that mirror some of the role experiences reported in the present study. Thomas et al. (1999) reported that steps were taken to help the interns to get to know the culture and roles in the collateral organization providing the internship so that they could join the system and develop collaborative relationships. In the present research, therapists took an active role in learning the culture of collaborative systems as well as pursuing an understanding of regulatory, institutional and family culture in order to manage changing roles in relation to the different systems.

The researchers outlined *strategies* that therapist-interns employed to increase their confidence in doing in-home work (Snyder & McCollum, 1999; Thomas et al., 1999). As their research was focused on mapping the developmental path towards reduced anxiety (i.e., role dissonance) and increased perception of self-efficacy, the strategies for achieving this were not analyzed. However, when the reported results are coded according to the present study, the strategies revealed examples of the agentic practices. For example, interns in the study reported calibrating their interactions with clients and making adjustments in sessions (*adaptive practices*), preparing materials to use in session in anticipation of having to change tack in session (*proactive practices* and *adaptive practices*), having conversations to set limits and clarify expectations (*communicative practices* and *sustaining practices*), and joining with clients so that they could effectively communicate and address concerns (*relational practices* and *communicative practices*); throughout the learning process, the interns engaged in reflective supervision and consulted with experienced professions to understand their role (*reflective practices* and *sustaining practices*; Snyder & McCollum, 1999, pp. 237-239). Reframing these strategies as agentic practices provides a frame for understanding these actions as creative acts that are not isolated in the learning phase, but reflect being professional overall. In line with the

therapists in the present study defining their role as a professional, one intern's approach to clarifying their role with clients was to define themselves as a "professional friend" (Snyder & McCollum, 1999, p. 238).

Revisiting understanding place in the system. Becoming knowledgeable about institutional, collateral organizations, and family culture is in many respects a proactive practice that contributes to performing professional roles. Through understanding the environmental context in terms of different roles, expectations, and perspectives, the therapist is in a position to locate where they stand and what roles they need to play. In much of the literature, this was often referred to as a domain of competency versus skill deficit. For instance, knowing their role, becoming knowledgeable about other systems, and developing the ability to work with other perspectives were amongst a list of necessary skills for HBFT (Adams & Maynard, 2000). Stinchfield (2004) called for greater awareness of the roles of other providers and the development of an understanding of other disciplines, whereas more recently, Lechtenberg (2014) placed emphasis on understanding family culture and therapists knowing their own role. Looking at this from the client perspective, clients reported appreciating therapists with lived experience who could relate to their situation (McWey, 2008; McWey et al, 2011). The findings in the study extend understanding systems to encompass regulatory bodies and insurance systems, as well as their employer's institution as additional domains to be familiar with (compare Quinones, 2013).

Supporting relational, communicative, and sustaining practices. In the present study, *building relationships* and *working collaboratively* are two relational practices that are relevant to managing roles. Building a therapeutic alliance places therapists in a better position to communicate, whether therapeutically, or for specific purposes like setting boundaries (Johnson,

Wright, & Ketring, 2002; Lechtenberg, 2014; Martel, 2008). Johnson et al. (2002) concluded their study on therapeutic alliance with the argument that in HBFT, therapists need to direct their focus with families towards getting on the same page and working as a collaborative team. Through engaging and maintaining rapport with families and collateral partners, therapists are able to establish working collaborative relationships (Adams & Maynard, 2000; Macchi & O'Connor, 2010). Stinchfield (2004) also identified joining as a competency that applies to family and community; the latter specifically is concerned with joining with professionals with the author noting that “There needs to be an understanding and respect for the role of each professional” (Stinchfield, 2004, p. 295). The importance of knowing their roles, communicating them, and establishing clear boundaries around them is supported by other research on professional roles (Alves & Gazzola, 2013; Lechtenberg, 2014).

Proactively utilizing formal and informal supports to manage roles and expectations, and as a measure of self-care are key elements of sustaining practices. Lechtenberg's (2014) research on therapists' role as agents of social control when working with mandated clients, identified that supervision around roles was particularly important for maintaining a social justice perspective. Elsewhere researchers have identified supervision and collaborative consultation around roles, boundaries, and suitable interventions as offering significant support when available (Martel, 2008). For HBFT therapists, receiving quality supervision and having a higher frequency of self-care activities enhances therapists' quality of life, even with high case-loads (Macchi, Johnson, & Durtschi, 2014). In a recent study, researchers corroborated the value of informal, coworker support as a sustaining practice, finding that high levels of coworker support played a moderating role with the stressors of workload and role ambiguity (Schulz, Schöllgen, & Fay, 2019). Considering that one of the roles that therapists perform in HBFT is assisting families to

locate and make use of social supports, it is paradoxical that the role of therapists' informal social supports as a factor in therapist self-care has not received much attention.

Adaptive and proactive practices. Proactive and adaptive practices are two dimensions of practice that have been addressed in the literature as requisite skills. Therapists proactively cultivate flexibility through the adaptive practices of adjusting their role, calibrating interactions, and accommodating to meet families where they are. Therapists in this study considered being flexible in terms of being able to switch roles on a moment's notice as one of the most important aspects of professionalism. Being flexible and culturally sensitive to the family has been endorsed as a requisite skill by other researchers (Adams & Maynard, 2000; Jager et al., 2009; Lechtenberg, 2014; Thomas et al., 1999). Families appreciate therapists who are accommodating and flexible with time, or who adjust their therapeutic role and approach in sessions (McWey, 2008; McWey et al., 2011). In the present study, the proactive practices of planning and organization are not restricted to administrative tasks or session planning, but incorporate being prepared for the different roles therapists might perform. Likewise, other researchers have found that taking steps to gather resources and develop plans for interpersonal interactions and self-care reduces therapist anxiety (Snyder & McCollum, 1999; Thomas et al., 1999). Numerous researchers have raised safety as an area of concern that requires more training (Christensen, 1995; Martel, 2008; Tate, et al., 2014). In comparison, therapists in this study were proactive in being prepared for different contingencies and potential crises: In particular, the agentic practices of *planning*, *utilizing supports*, and *communicating* are focused on handling safety concerns; however, ultimately all the agentic practices come in to play when therapists incorporate *setting boundaries*, and *working collaboratively* on developing safety plans.

Although examples of the six agentic practices can be found in the literature as skills or competencies, this research offers a fresh picture of professionalism in HBFT, supported by cultivating professional agency. In being professional, therapists maintain their professional integrity and are mindful of their place in the system while engaging in agentic practices.

Strengths and Limitations

There are limitations to this study, primarily related to the sample. Firstly, the sample was limited to 12 therapists, five of whom had left HBFT practice (one temporarily) to do outpatient work. In grounded theory studies there are always concerns that small samples may not provide sufficient data to study a topic in depth. Through follow up interviews, the use of multiple data sources, and consultation with peers I have made an effort to go beyond general consensus to explore both areas of agreement and dissonance until I was no longer getting new material. An effort was made to draw participants with varying degrees of experience working in different contexts, however it is recognized that the participants do not represent program diversity on a national level, or racial diversity in the field.

With respect to diversity, the sample included seven female and five male therapists who self-identified as ten Caucasians, one Hispanic, and one Asian. No African American or candidates from other minority groups are represented. There were some indications that there were specific challenges that therapists from minority groups experienced in being professional in HBFT relating to intersectionality of personal and professional identities, that were not explored in this study beyond setting boundaries and utilizing supports. An in-depth exploration of intersectionality of therapists' personal and professional identities and the implications for managing professional roles in HBFT was beyond the scope of this study and would merit further research.

The fact that five of the 12 therapists had left their HBFT positions could be misinterpreted as an indicator that they found the job unmanageable. As a subgroup, their time in HBFT ranged from one to eight years; two of the therapists had left HBFT after a year and two had left after three years; another reported that they were taking a temporary leave of absence. Therapists gave various reasons for changing jobs, including the position being less flexible than expected, relocation and not finding a HBFT position, starting private practice, feeling burnt out from institutional work demands, countertransference issues, and needing to spend more time with their own families. Having left, several therapists indicated that there were elements of the collaborative work that they felt was lacking in outpatient work and that to the extent allowed, their practice continued to be informed by their HBFT experience. As indicated in the research, managing professional roles in HBFT is an ongoing process, and the intimation that leaving HBFT reflected on their ability to manage roles does not correspond with therapists' narratives demonstrating areas of learning and successful management.

As the study was presented as being concerned with how MFTs managed their professional roles in HBFT, it is possible that the topic focus was sufficient to bias them towards on thinking in terms of their identity as an MFT. In the interview process, a deliberate effort was made to frame questions in terms of being a home-based family therapist, however, therapists frequently responded from the position of being an MFT. At the end, in consideration that many of the therapist referrals of potential participants were colleagues from other professions suggests that participants were not being influenced to speak as MFTs, but were also speaking as HBFTs.

There are limitations to the generalizability of this study: Namely, as institutional and environmental contexts are relevant to therapist professional roles and identity development, the characteristics of this small sample limit the generalizability of this research. Furthermore, to the

extent that feeling grounded in their professional identity as MFTs, particularly with respect to training in family systems theory, was seen as critical to managing professional roles in HBFT, another limitation of this research concerns the degree to which it can be generalized to other mental health disciplines that may not include this training.

Future Directions

As many states move towards instituting system of care practices as an organizing approach to meeting the mental health needs of children and youth at risk, there will be an increased demand for therapists who are ready to work in HBFT programs. MFTs have a distinct advantage in being trained in family systems and systemic perspectives. Integrating coverage of HBFT practices across the MFT curriculum domains, by addressing them in the context of ethics and professional identity development, systemic interventions, and collaborative practices would help therapists contextualize the learning. Learning reflective practices through supervision has relevance to all students regardless of treatment modality. Inclusion of opportunities to learn about the perspectives and roles of potential collateral partners working in other institutions, including child welfare, juvenile justice, the legal system, and schools in therapist training through meeting representatives from the respective professions is recommended in masters level training to lay the groundwork for therapists developing a personal practice of broadening their understanding regardless of their future work setting. Therapists who make a point of understanding the roles and perspectives of players in the systems that families are involved with are better situated to assist the families navigating these systems. Likewise, gaining experience in clarifying roles and negotiating different perspectives to find common goals is a component of collaborative work that would benefit all MFTs.

With respect to clinical training, it was notable that four of the five therapists who had left HBFT within three years of practice had their first HBFT experience post-masters. These therapists spoke highly of what they learned from the experience and incorporated in their general practice. The findings of this research concur with Thomas et al. (1999) who found that student clinicians benefited from having in-home experience, recommending that incorporating exposure to meeting families in the home is included in clinical training.

MFTs working in institutions can play a leadership role in articulating how the distinct strengths that MFTs bring to HBFT are important for interdisciplinary work. Based on therapists' critiques of the workplace, there is a place for systemically-informed leadership to address some of the institutional barriers to working systemically both on the organizational and policy level. At the institutional level, for organizations to provide regular opportunities for therapists to get to know the other stakeholders they will be working with so that they understand each other's perspectives would work towards improved collaborative relationships and reduce role ambiguity. Although many organizations provide training in role expectations, ensuring that employees know what their roles are and how they should be articulated helps reduce role confusion and helps promote a clear HBFT identity. For new therapists having more certainty around their roles could accelerate acculturation to the position.

When recruiting, I received a number of expressions of interest from clinicians who were not MFTs, but were interested in the topic of the study. Given that the therapists in this study felt that they had an advantage over their co-workers having family systems training, introducing coursework in systemic theories, interventions, and principles of collaborative work is recommended to the other allied mental health professions.

Finally, since HBFT is concerned with privileging the youth and family voice, there needs to be more opportunities to bring the families' experience and perspectives of HBFT services to the fore. Given that therapists may not perform the same roles with different family members, it is unlikely that families' have a uniform experience of HBFT. Building on the limited research on family perspectives in HBFT (Johnson et al., 2002; McWey, 2008; McWey et al., 2011), further studies that explore both youth and caregivers' perspectives on how they experience HBFT, their relationship with their therapist, and their understanding of the therapists' roles in their work together, would enhance our understanding of how families experience therapists navigating multiple roles in HBFT.

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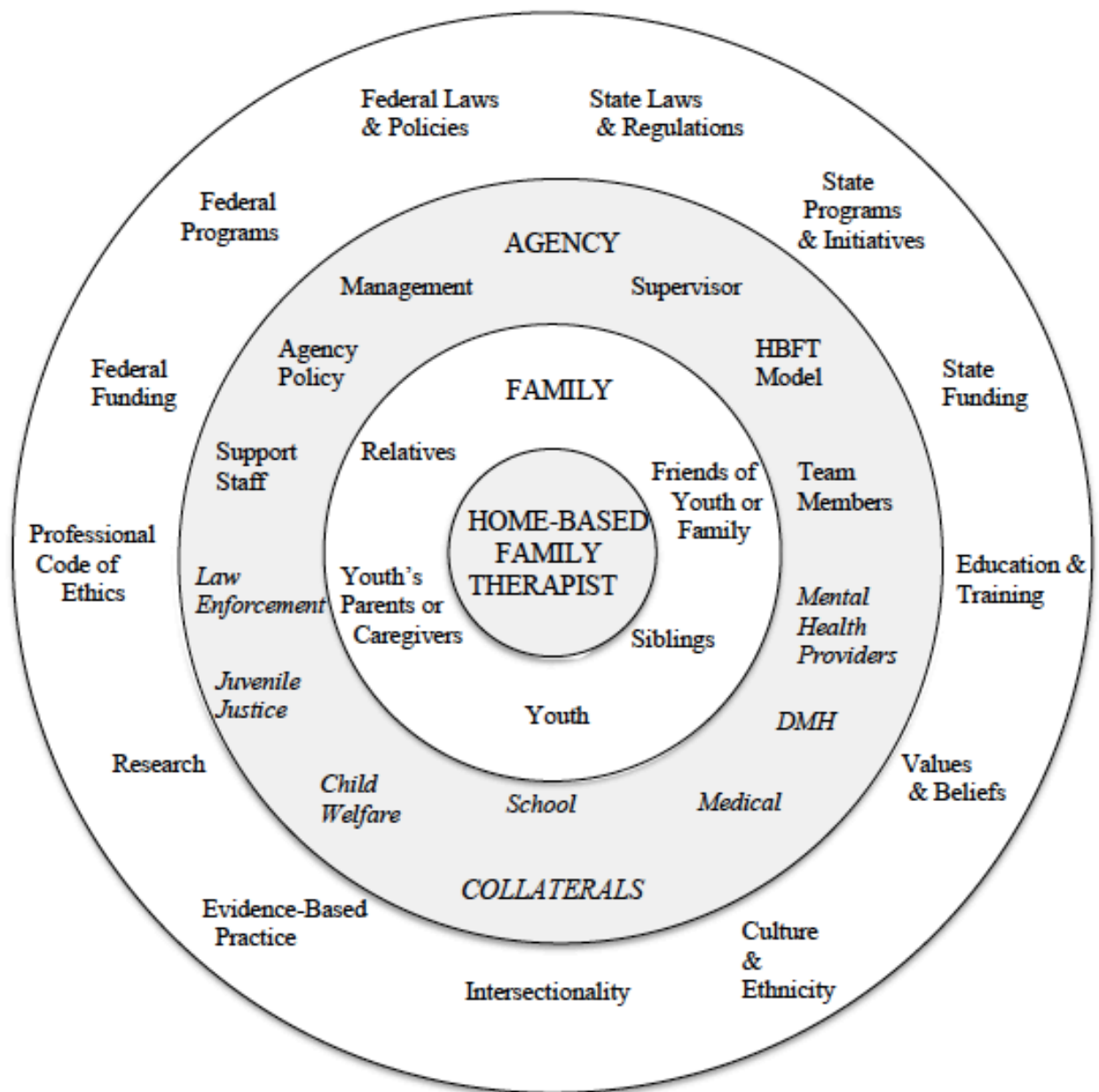
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Appendix A

HBFT Situational Map



Appendix B

Institutional Review Board Approval and Amendment



Sharon Fitzgerald <sfitzgerald@antioch.edu>

Online IRB Application Approved: Managing Multiple Professional Roles in Home-Based Family Therapy: A Study of Marriage and Family Therapist Practices December 8, 2016, 12:00 am

1 message

klynness@antioch.edu <klynness@antioch.edu>

Thu, Dec 8, 2016 at 12:00 AM

To: sfitzgerald@antioch.edu, klynness@antioch.edu, bsammons@antioch.edu

Dear Sharon Fitzgerald ,

As Chair of the Institutional Review Board (IRB) for 'Antioch University , I am letting you know that the committee has reviewed your Ethics Application.

Based on the information presented in your Ethics Application, your study has been approved.

Your data collection is approved from 12/12/2016 to 12/11/2017. If your data collection should extend beyond this time period, you are required to submit a Request for Extension Application to the IRB. Any changes in the protocol(s) for this study must be formally requested by submitting a request for amendment from the IRB committee. Any adverse event, should one occur during this study, must be reported immediately to the IRB committee. Please review the IRB forms available for these exceptional circumstances.

Sincerely,

Kevin Lyness

Amendment

Sharon Fitzgerald <sfitzgerald@antioch.edu>

Online IRB Application Approved: Managing Multiple Professional Roles in Home-Based Family Therapy: A Study of Marriage and Family Therapist Practices August 22, 2017, 1:29 pm

1 message

klynness@antioch.edu <klynness@antioch.edu>

Tue, Aug 22, 2017 at 1:29 PM

To: sfitzgerald@antioch.edu, klynness@antioch.edu, bsammons@antioch.edu

Dear Sharon Fitzgerald ,

As Chair of the Institutional Review Board (IRB) for 'Antioch University New England, I am letting you know that the committee has reviewed your Ethics Application. Based on the information presented in your Ethics Application, your study has been approved.

Your data collection is approved from 08/22/2017 to 08/21/2018. If your data collection should extend beyond this time period, you are required to submit a Request for Extension Application to the IRB. Any changes in the protocol(s) for this study must be formally requested by submitting a request for amendment from the IRB committee. Any adverse event, should one occur during this study, must be reported immediately to the IRB committee. Please review the IRB forms available for these exceptional circumstances.

Sincerely,

Kevin Lyness

Appendix C

Informed Consent

Title: MANAGING PROFESSIONAL ROLES IN HOME-BASED FAMILY THERAPY

Purpose of the study

The purpose of this research is to investigate how marriage and family therapists manage professional roles working with families and larger systems. I plan to develop a practice model for home-based family therapists based on conversations with therapists with experience in the field.

Recruitment

You have been invited to participate in this study because you are a marriage and family therapist who has experience doing home-based family therapy. You may have received an invitation because you are a member of AAMFT, or you are a graduate from a marriage and family therapy program, or you work for an agency that employs marriage and family therapists that provide home-based family therapy services. Some participants are recruited by “snowball sampling”. This means that I received your name from an individual who believes that you have expertise as a home-based family therapist. In order to recruit other knowledgeable participants, I will ask you provide the name(s) and contact information of colleagues who might be interested in participating in the study. You may choose whether you are willing to have your name revealed to the potential contact or whether you wish to remain anonymous. You may also decline to nominate others.

Procedure

If you decide to participate, you will be asked to complete a short demographic survey. I will then ask you some questions about your roles as a home-based family therapist. This interview is expected to take about an hour and will be audio-recorded. I have budgeted a maximum of 90 minutes for the entire process from start to finish. You can tell me how much time you have available and when you would like to end. At the end of our dialogue you can decide whether you are willing to be contacted for follow-up questions or a second (30 minute) interview at a later date.

Risks

The risk of participating in this research is minimal. You may find it inconvenient to take time out of your busy schedule to participate. You may experience discomfort or embarrassment when

recalling a challenging work experience. You do not have to answer any question that makes you feel uncomfortable.

Benefits

There is no direct benefit to you for participating in this research. However, you will be providing valuable information that may be beneficial to the training and supervision of therapists who provide home-based family therapy.

Participant Rights

Your participation is voluntary. You may choose to withdraw at any time without penalty. If you have any questions about your rights as a participant or the manner in which this research is conducted, you may contact Kevin Lyness, Ph.D., Institutional Review Board Committee Chair, (phone number), klyness@antioch.edu or Melinda Treadwell, Ph.D., Provost, Office of Academic Affairs, (phone number), mtreadwell@antioch.edu.

Confidentiality

All information collected in this research will be treated as confidential. I plan to transcribe the audio-recordings; if I need to hire a transcriber that individual will be bound to confidentiality. Names of individuals, organizations and personal identifiers will be excluded from the transcripts. Information, including direct quotes, will be reported in a non-identifying manner. I will keep your name and contact information in a separate locked file. If you decide to provide names and contact information of potential participants, your name will not be revealed unless you have previously agreed to share your identity. Research documentation and audio recordings will be retained for five years in an encrypted file.

Reimbursement

In appreciation for your time and as an incentive for self-care, you will be provided the opportunity to select a \$25 gift card to either Starbucks Coffee or Amazon.com when we complete the first interview. This is yours to keep even if you are not available for the second interview or decide later that you don't want me to use your information in the study.

Sharing of Research Results

The results of this research will be submitted for publication in a journal read by marriage and family therapists, such as the *Journal of Marital and Family Therapy*, or *Contemporary Family Therapy*. The principal investigator may present the results of this research at marriage and family therapy conferences or to groups with an interest in home-based family therapy.

Questions

If you have any questions about this project, please do not hesitate to contact the principal investigator, Sharon Fitzgerald, at (phone number) or sfitzgerald@antioch.edu.

Informed Consent

I have read the information above and my questions about the research have been answered to my satisfaction. I agree to participate in this research. I understand that I can withdraw at any time by informing the principal investigator. I have received a copy of this form.

Signature

Date

Printed Name

Preferred Contact Information (phone or email)

☐ Yes, I am willing to be contacted by the principal investigator to answer follow-up questions.

☐ Yes, I am willing to be contacted by the principal investigator for a second interview at a later date.

Potential Recruit Recommendations

Name

Contact Information (phone or email)

☐ I agree to allow my name to be revealed to the contacts listed.

☐ I decline to have my name revealed to the contacts listed.

Appendix D

Invitations to Participate in Study

Recruitment Letter on Letterhead

Insert date

Dear Therapist,

My name is Sharon Fitzgerald and I am a doctoral candidate at Antioch University New England. You are receiving this letter because you work in a setting that offers intensive, home-based family therapy services.

I am seeking in-home therapists with marriage and family therapy training to participate in my research on the practices and experiences of marriage and family therapists who provide home-based family therapy. The purpose of this research is to gain an understanding of how marriage and family therapists manage professional roles when working with families and larger systems in home-based family therapy.

If you are a marriage and family therapist with experience providing home-based family therapy and are willing to share your experience with me, I would like to hear from you! Your participation will contribute to knowledge about working with families in the home and community that will be of value to other therapists working in the field.

If you would like to be involved in this project, the first step is to contact me to learn more about the study and your rights as a participant. If you choose to participate you will be asked to complete a demographic survey and make time in your schedule for 1-2 interviews, totaling two hours of your time. You will receive a \$25 gift-card as a thank you for taking part in the interviews. Participation is entirely voluntary and you are under no obligation to follow through with the research if you respond to this invitation.

If you are interested in participating or would like to learn more about the study, please contact me by email (sfitzgerald@antioch.edu) or by phone (xxx-xxx-xxxx) to set up a time for us to talk.

Please forward this request on to other home-based family therapists who you think might be interested in participating in this research. Thank you!

Sincerely,
Sharon Fitzgerald, MA LMFT
(University address)

Recruitment Letter Template for Snowball

Dear _____,

My name is Sharon Fitzgerald and I am a doctoral candidate at Antioch University New England. [EITHER] I have received your name from _____ (if referral source agreed to disclosure of name) who suggested that you might be interested in participating the study I am conducting for my dissertation. [OR] I have been given your name by a _____ (friend/colleague/participant if referral source prefers to remain anonymous) who suggested that you might be interested in participating the study I am conducting for my dissertation.

I am seeking in-home therapists with marriage and family therapy training to participate in my research on the practices and experiences of marriage and family therapists who provide home-based family therapy. The purpose of this research is to gain an understanding of how marriage and family therapists manage professional roles when working with families and larger systems in home-based family therapy.

If you are a marriage and family therapist with experience providing home-based family therapy and are willing to share your experience with me, I would like to hear from you! Your participation will contribute to knowledge about working with families in the home and community that will be of value to other therapists working in the field.

If you would like to be involved in this project, the first step is to contact me to learn more about the study and your rights as a participant. If you choose to participate you will be asked to complete a demographic survey and make time in your schedule for 1-2 interviews, totaling two hours of your time. You will receive a \$25 gift-card as a thank you for taking part in the interviews. Participation is entirely voluntary and you are under no obligation to follow through with the research if you respond to this invitation.

If you are interested in participating or would like to learn more about the study, please contact me by email (sfitzgerald@antioch.edu) or by phone (xx-xxx-xxxx) to set up a time for us to talk.

Please forward this request on to other home-based family therapists who you think might be interested in participating in this research. Thank you!

Sincerely,

Sharon Fitzgerald, MA LMFT
(University address)

MFT Group Facebook Post

Hello!

I am seeking MFTs with experience doing home-based family therapy to participate in my dissertation research. The purpose of this research is to gain an understanding of how marriage and family therapists manage professional roles when working with families and larger systems in home-based family therapy.

If you have post-masters experience providing home-based family therapy and are willing to share your experience with me, I would like to hear from you! Your participation will contribute to knowledge about working with families in the home and community that will be of value to other therapists working in the field.

If you would like to be involved in this project, the first step is to contact me to learn more about the study and your rights as a participant: sfitzgerald@antioch.edu. Participation is entirely voluntary and you are under no obligation to follow through with the research if you respond to this invitation. Please share if you know someone else who may be interested. Thanks!

Appendix E

Home-Based Family Therapist Demographic Questionnaire

Your answers to the following questions will remain confidential.

Which best describes your training in marriage and family therapy (MFT)?

- ☐ Degree from COAMFTE accredited institution
☐ Degree from non-accredited institution
☐ Post-graduate clinical training program
☐ Other (describe) _____

Check the highest degree completed: ☐ MA ☐ MS ☐ PsyD ☐ PhD ☐ Other _____

How many years have you worked as a therapist since graduation?

- ☐ Less than one year
☐ _____ years (write in)

Are you currently licensed as a LMFT to practice in your state of employment?

- ☐ Yes
☐ No, but I am license eligible.
☐ No, but I am licensed as _____ (license title) in _____ (state).

Are you a member of AAMFT? ☐ Yes ☐ No

Indicate the training you have had in home-based therapy (mark all that apply):

- ☐ in degree program ☐ conference workshop ☐ agency sponsored training ☐ supervision
☐ other (describe) _____

How long have you worked as a home-based family therapist?

- ☐ 6-12 months
☐ _____ years (write in)

What is your agency & job title? _____

Describe your client demographics _____

What is your age? _____ What is your gender? _____

How do you identify yourself (select all that apply)?

- ☐ African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Caucasian ☐ Hispanic/Latino/Latina
☐ Pacific Islander ☐ Other _____

THANK YOU!

Appendix F

Interview Guide

Welcome

Thank you for agreeing to this interview and for making time in your schedule to meet with me.

Informed consent

Before we talk about your experiences as a home-based family therapist, I would like to review the consent form with you and answer any questions you might have about the study.

Purpose of the research

Many therapists report that being a home-based family therapist is different from being an outpatient therapist or doing outreach and talk about how home-based family therapists are called upon to play many roles when working with families and multiple systems. Besides the various configurations of individual and family therapy, these roles may include case manager, advocate, educator, crisis responder, coach, and guest in the client's home. Other roles include relationships within the agency—as a team member, supervisee, employee—and professional roles with other service providers outside of the agency. I am interested in learning more about how marriage and family therapists manage their different professional roles in home-based family therapy.

Sample questions for a semi-structured initial interview.

1. In order to understand the work you do, I would like to start out by asking a few questions about your job and where you work. What are your job responsibilities? Tell me how home-based family therapy teams are organized? What are the responsibilities of _____(other team members)?

2. Tell me what it is like to be a home-based family therapist. What do you like most about your work? What do you like least? Briefly describe what you do in a typical week.
3. What are the different roles you play as a home-based family therapist? [Participants will be provided a graphic or list of roles commonly experienced with clients, employers, and outside agencies: Roles with clients include case manager, advocate, educator, crisis responder, coach, and guest in the client's home; roles within the agency include being a team member, supervisee, employee; and professional roles with external agencies include mandated reporter, collaborator, evaluator.] How compatible are your different roles? What expectations go with _____ roles?
4. In what ways has your training prepared you to handle different role and boundary-related situations in home-based family therapy?
5. What successes have you experienced in managing different role expectations? I would like to learn how you handle these successes: If you can, please share an example, without identifying information, of how you balance different roles. Prompts to expand description: Tell me more about that. If we were to break this down, what do you do first? Then what? What are your thoughts and feelings in these situations? If you recall, how did you learn to manage situations like _____?
6. What challenges have you experienced in managing different role expectations? How have you handled these challenges? Please share an example, without identifying information, of managing different roles under these circumstances [prompts to expand description as above; explore similarities and differences]. If you were in the same situation again, how would you handle it now?

7. What other role or boundary related situations have you encountered as a home-based family therapist? Please describe how you managed them [prompts to expand description as above]. What contextual factors influence these situations? [Examples of contextual factors include client demographics, time, location, life events.]
8. [If not previously addressed] You may choose to answer this question to the degree that you feel comfortable: To what extent have you considered any of the role and boundary related situations that you have experienced in home-based family therapy as an ethical issue? What were your concerns? Please describe how you have handled _____. [prompts to expand description as above].
9. Tell me what (or who) has been most helpful in supporting your balancing expectations associated with different roles or boundaries? How has this (they) been helpful to you?
10. How has managing different roles been addressed in supervision? or Have you ever wanted to talk about role or boundary related situations with your supervisor? Tell me about how that has influenced how you manage _____ (situation)?
11. Based on your experience, what advice about managing roles/boundaries would you give to someone new to the job?
12. Is there something else you think I should know about being a [HBFT job title]?
13. What do you see yourself doing in five years?
14. Is there anything you would like to ask me?

Appendix G

Transcription Guidelines

Labeling Transcripts

In the header the transcription will indicate Date of Interview (YYMMDD) and Assigned Interviewee ID separated by a hyphen. The document will be paginated and time markers will be at the top-left of each page. The file will be labeled in the same manner.

Formatting the Transcript

A master transcript will be formatted using the following conventions:

- 12 point Times New Roman, double-spaced
- 1" margins; left justified
- Interviewer will be designated as #SF#
- Participant will be designated by #Interviewee ID#
- Speaker will be identified by ID followed by indented dialogue

For coding purposes, the page orientation will be changed to landscape, with a 1.0" left margin and a 3.5" right margin allowing for a coding text box. In the coding transcript, lines will be numerated for referencing purposes.

Content

Verbal. The master transcript will be verbatim with the purpose of accurately recording meaning. It is not intended to capture accent, dialect or speech variants. The transcription will include:

- Response tokens (intentional vocalizations that have meaning): *um, uh, hm, ah, ahah, yeah, ok, ugh, uh huh/nuh uh, huh*, and etc. Utterances associated with a speech impediment are excepted from the transcription.

- Mispronounced words will be transcribed with conventional spelling unless the meaning is ambiguous; if there is doubt the transcription will represent the word as said and the proposed correction will appear in brackets separated by a forward slash: [/correction/].
- Inaudible words will be designated by [inaudible], unless due to overlapping speech where it will be designated by [cross talk] inserted at starting point of overlap.
- Distinguishable overlapping speech will be notated by insertion of [*cross talk] in first speaker's text at starting point of overlap, and introducing second speaker's dialogue with [*cross talk]. End of cross talk will be indicated by [*] in each speaker's dialogue.

[Change made after interview 6: Response token cross-talk will not be recorded unless it contributes to a shift in the conversation or change in meaning as determined by transcriber.]

- Emphasized words will be written in bold font.
- Where there is a matter of doubt in the transcription, the section will be highlighted so that it can be reviewed for accuracy in the next pass.

Non-verbal. The transcription is concerned only with non-verbal sounds or silences that take place between the speakers. Contextual sounds will be documented in field notes.

- Non-verbal sounds made by the interviewee or interviewer will be recorded in parentheses, for example (laughter).
- Pauses will be designated in the following manner:

- Short interruption in speech < 2 seconds is indicated by a comma

[First transcription change: Add *where grammatical, or a slash / for number of seconds greater than 1.*]

- Brief pause of 2-5 seconds is indicated with a hyphen.

[First transcription change: Replace with *Brief pause is indicated by a slash / per second up to 10.*]

- A change in direction, or omission is indicated with three ellipses; four ellipses if there is a trailing off (incomplete sentence).
- A long pause before the start of speech, or continuation of speech will be indicated by the term (long pause) with the inclusion of minutes of silence if it is greater than one minute.

Confidentiality and identifying information. Where personal names or potentially identifying locations, or entities are mentioned in the interview they will be demarcated in the interview with an equal sign on either side when transcribed, for example =name=. The researcher will review the master transcript for potentially sensitive information that will be replaced with a descriptive substitute, for example =employer=, in the coding transcript. The interviewee's ID will replace any occurrence of his/her name in the interview.